Health policy making and implementation in France 1970-1981

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HEALTH POLICY MAKING AND IMPLEMENTATION IN FRANCE

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INTRODUCTION

The political institutions of a country have, by tradition and almost by definition, been the subject matter of political scientists. France is no exception. Historians and political scientists have analysed the five written constitutions and the various other aspects of French political heritage in considerable detail. The similarities and differences between these different 'states' have been compared and contrasted. Conclusions have been drawn about the cultural traits represented by each. The main sources of power have been identified, or the absence of any such source noted. More recently the Vth constitution has been examined in detail. Here researchers have concentrated their attention on a small number of political actions and specific aspects of the political institutions in their analysis of the political system.

This approach to political systems is however by no means the only one. In recent years a number of political scientists have adopted a policy based approach to political systems. The basis of this approach is the assumption that the object of the political scientists is to determine not whether a political system is Presidential or Parliamentary two party or multi-party, but the significance of this for policy outputs. In other words the object of this approach is to analyse what governments do, and the effect of their actions, as well as why they do them?

An important by-product of this approach is the work that has been put in to analysing some of the main concepts involved here - such as 'policy' itself and 'power'. Not surprisingly this new approach has produced a number of new theories about the process of decision making within specific political systems, and in general. Not all of these rely

on political institutions as the basis for their explanations.

The area of Health Policy has in recent years attracted the attention of a number of analysts for a variety of reasons. One is undoubtedly the 'gut' reaction felt by many in Western European countries since the 2nd World War that health care, like education, should be either provided free of charge, or provided by means of a system that ensures a minimum basic standard of health care for all. Analysts have set out to examine how successful various governments have been in achieving this objective. However, in more recent years health policy has attracted attention for another reason - the spiralling cost of health care, and the apparent inability of governments to control the escalation of these costs. This has led analysts to examine different systems of health delivery in search of the most economic, or alternatively to look at the various sets of actors within this policy area, and their different roles. Not surprisingly, researchers have put forward theories stressing the 'uniqueness' of this area of policy, and stressed the special nature of 'Health' as a policy. Not surprisingly either, political institutions do not feature prominently as important explanatory features in the conclusions of policy analysts in this area.

It is my contention that the three approaches outlined above all suffer from their own shortcomings although the ultimate objective of each is the same - the better understanding of the way political systems work. It is also my contention that a combination of the best elements of each of the above approaches can help in decyphering the complexity of the decision making process.

In the remaining chapters of part one I have analysed in more detail

the three bodies of literature outlined above, identifying the major themes in each, and the limits of the various theories adopted.

In part two I shall give a brief overview of the development of the French health system up until 1970, and an analysis of the situation facing French policy makers at that date, in preparation for part three in which I analysed two defined policy issues over a period of eleven years between 1970 and 1981.

The ultimate objective is therefore to utilise the different approaches and questions raised in each of the three areas identified above to provide a fuller, more nuanced analysis of the process of decision making in the area of health policy in France.

PART ONE

POLICY, POLITICS AND HEALTH

Chapter One

THE POLITICAL INSTITUTIONS OF FRANCE

Three major themes can be clearly identified in the literature of French government and politics. The issue of Presidential power has been a major theme since the beginning of the Vth Republic. However, this theme also predates the Vth Republic as it is also the main issue in the analysis of the conflicting constitutional traditions of France. A second theme concentrates on the role of the administration This takes two forms. Firstly the traditional interest in the power of the Administration. In recent years, analysts have switched their attention from the general issue of the power of the Administration as a whole to the small but reputedly highly influential 'Grands Corps'. The second aspect of this theme is the central/local dimension. In this, the model of France as a highly centralised and bureaucratic state has been increasingly qualified. The third theme, less common but equally important, is the role of interest groups in the French political system. The initial assumption of this thesis is that a policy based approach to French politics and government will enable us to contribute useful insights to all three of these themes.

1.i. **Presidential Power**

If Ashford is correct, then the starting point for any analysis of policy must be with the constitution of the country concerned.[1] While taking Ashford's point that the institutional context and history of a country are essential to the understanding of policy, it is worth noting that constitutions, like policies, may be more important for what they leave unsaid, or partly said, than for their face value. The constitution

of the Vth Republic is a case in point. At a press conference in January 1964, de Gaulle defined a constitution as being made up of 'un esprit, des institutions, une pratique'. While a constitution may clearly define the institutions of a country, the 'spirit' of a constitution and the uses to which it is put are at least as important, as de Gaulle showed on numerous occasions.

The 1958 constitution divides executive power between the President and the Government. Amongst the most important powers reserved for the President is the right to appoint the Prime Minister (Article 8), to dissolve the National Assembly (Article 12), and the right to take special powers in the case of an emergency. On the other hand, Article 20 of the constitution states that the Government under the Prime Minister 'determines and conducts the policy of the nation'. The government is responsible to the National Assembly and fixes its agenda (Article 48). According to the constitution a number of the powers of the President are in theory shared with the Prime Minister. Thus the President appoints government ministers proposed by the Prime Minister. The President may ask Parliament to reconsider a bill, but this request must be countersigned by the Prime Minister. One of the most significant powers of the President is to submit constitutional reforms, or any policy proposal, to a referendum, but again according to the constitution this power can only be exercised on the initiative of the Prime Minister. The power of the President to promulgate decrees and regulations decoded in the council of Ministers, or to make top appointments in the civil service, diplomatic service and the army, are only valid if countersigned by the Prime Minister. As Wright observes, on paper the constitution does not clearly place all power in the hands of the President.[2]

Hayward describes the constitution as 'periodical literature', arguing that its only value is that it reflects the conflicting governmental traditions of France. These traditional 'limits' defined by history that are important for decision making are, according to Hayward, of far greater significance. Hayward identifies an authoritarian tradition as manifested in the absolute monarchy, the Napoleonic Empires and, most recently, the Vth Republic, which alternates with regimes which are the expression of a more liberal tradition and where representation is emphasised, as in the IIIrd and IVth Republic. According to Hayward, the legacy of political practice and institutions of these two contrasting traditions 'collectively incorporate the values which shape day-to-day political behaviour'.[3]

According to Hayward, although the Vth Republic can be seen as a direct descendant of this authoritarian tradition, the institutions remain essentially fragile, as they are in contradiction to the second constitutional tradition. The source of this fragility lies in the nature of France, which Hayward describes as:

> A country of counterbalancing contradictions. It combines anarchic individualism and centralized statism. Revolutionary responses and rhetoric are combined with the conservative traditionalism of entrenched vested interests. Instability and continuity coexist in extreme forms.[4]

This, he argues, has produced a political élite with a belief in the need for a strong centralised authority to counteract 'the centrifugal forces that constantly threaten the integrity of the State'.[5]

Wright's reading of the constitution is that it is 'an ambiguous affair', the result of unhappy compromises between men who held basically

conflicting views on the future distribution of political power.[6] However, Hanley, Kerr and Waites argue that it is this very ambiguity which places the constitution squarely in the authoritarian tradition of French constitutions, since 'the President may decide as he thinks fit how he will interpret the constitution's description of his powers'.[7]

Whether the constitution is ambiguous or clear, authoritarian or otherwise, the practice of successive incumbents has clearly been a crucial factor. According to Frears, 'Presidential supremacy has been the practice right from the start'.[8] This is explained firstly as a result of the personality of de Gaulle, and secondly the changed party structure that came into being during the Vth Republic. The constitution of 1958 was in part designed to rectify the instability of governments, victim of a multi-party system. However, through the existence of the Vth Republic, Presidents have been able to rely on the support of if not an absolute majority of one party, then on a stable coalition of parties with an absolute majority.

As a result of the existence of a majority in Parliament based on support for the President, the numerous constraints on Presidential power provided for in the constitution have been rendered ineffective, and the position of the Prime Minister weakened. However, it is the practice to which de Gaulle and successive Presidents have put the constitution that has clearly established Presidential supremacy. Practice has clearly established that the President not only appoints the Prime Minister, but may also sack him. Practice has established that the Prime Minister and his Ministers execute the policies of the President. Practice has established a 'domaine réservé', the policy areas where the President is directly involved in the policy making process. Practice has seen

the 'domaine réservé' expand from foreign policy under de Gaulle, to include economic and industrial policy under Pompidou, and social, political and environmental policy under Giscard d'Estaing. The National Assembly has only rarely attempted to resist this erosion of their sphere of influence.* Thus, according to John Frears, 'So long as a French President has a parliamentary majority, unwilling to overthrow the government he appoints or to reject the laws it proposes, he has more concentrated executive power in his hands than any other western leader'[9] (my emphasis). Further on, Frears argues that:

> The French President has become a marvellous instrument for political action... The President's almost unlimited powers to make appointments to all important posts in the public service, to direct every aspect of public policy, to make all important declarations, are contested neither by the Prime Minister, nor by Parliament... The possibility, therefore, for coherent personal direction of affairs by one outstanding individual is unparalleled'.[10]

In stark contrast are Vincent Wright's conclusions on the nature and extent of Presidential power in France. Wright stresses the complexity of both the problems faced by decision makers, and the network of competing forces limiting the President's powers. According to Wright, Presidential power is limited in the first place by the extent of his responsibilities. The wider these become the less time he has available to devote to each and the more he is obliged to delegate detailed policy making to his nominees. Although the power of the parties has been weakened, Wright claims that the President still depends on their benign neglect to retain his influence, and that the parties within the National

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* During the Presidency of Giscard, the RPR did on a number of occasions vote against the government, while never taking the crucial step of voting a motion of censure.

Assembly, while not having the power to initiate policy, still determine the boundaries of what it is possible for the President to do. Powerful interests within French society also have the possibility of blocking Presidential policy initiatives. Thus Wright concludes, 'There exists, therefore, a combination of personal, constitutional, administrative and political factors which severely constrain the President'.[11] According to Wright, given the complexity of modern government, it is impossible to pinpoint the decision-making centres in society, and that no clear pattern of power is discernible. Thus, he argues,

> Decision making under the Vth Republic takes place, therefore, within limits defined by history, and by the outside world. Within these limits, decisions emerge as the result of interaction, or non-interaction (for mutual avoidance may be profitable) of a chaos of decision makers who function at a national, regional, and local level. Power is diffused amongst a host of bodies... all of which are fragmented and divided.[12]

The contrast between the interpretations of Presidential power of Frears and Wright is striking. Although Frears suggests that the power of the President is great, it is not exactly clear what he means by 'power'. Does he mean that the President simply determines the broad lines of policy in all areas, while the details of policy and the implementation of policy are left to the Ministers and the civil service? If that is the case, then the 'power' of the President is relatively meaningless. Wright argues that government is too complex for any meaningful estimation of Presidential power to be made. But complexity is a problem facing political scientists, whatever the country concerned. The role of the political scientist is to attempt to decipher that complexity. Whether Frears or Wright is correct, it seems reasonable to assume that the factors limiting Presidential power will vary from policy area to policy area,

and that the 'power' of the President should not be analysed in a vacuum or in the abstract. It is important that the issue of power be analysed in relation to a defined policy area. In other words the question to be addressed is 'power to do what?' In this way, although the problems of complexity will not be avoided, as even in a limited policy area the number of actors and conflicting forces will be great, there is a higher probability of getting closer to the truth than with a more general analysis.

As the aim of this analysis is not to determine the power of the President, nor even to describe the role of the President in health policy making, but to understand how health policy is made in France, the role of the President may prove to be of no great importance. The nature and importance of other aspects of French political institutions must therefore also be considered.

1.ii. **Central Aspects of the 'Unitary' State**

From the President it is only natural that attention should shift to the bureaucracy. The fact that the constitution has reduced the power of the parliament, and whether or not the President is powerful, means that the administration plays an important part in the formation and implementation of policy. The power of the bureaucracy has traditionally been an important issue in political science literature, and France has long attracted particular attention as a model of a highly centralised bureaucracy. The focus of attention in the literature on France has been on the élite of the civil service, who seem to play an extremely important policy making as well as political role. For some, these are highly trained and efficient administrators.[13] For others, they help perform the State's essential function of serving the interests of a

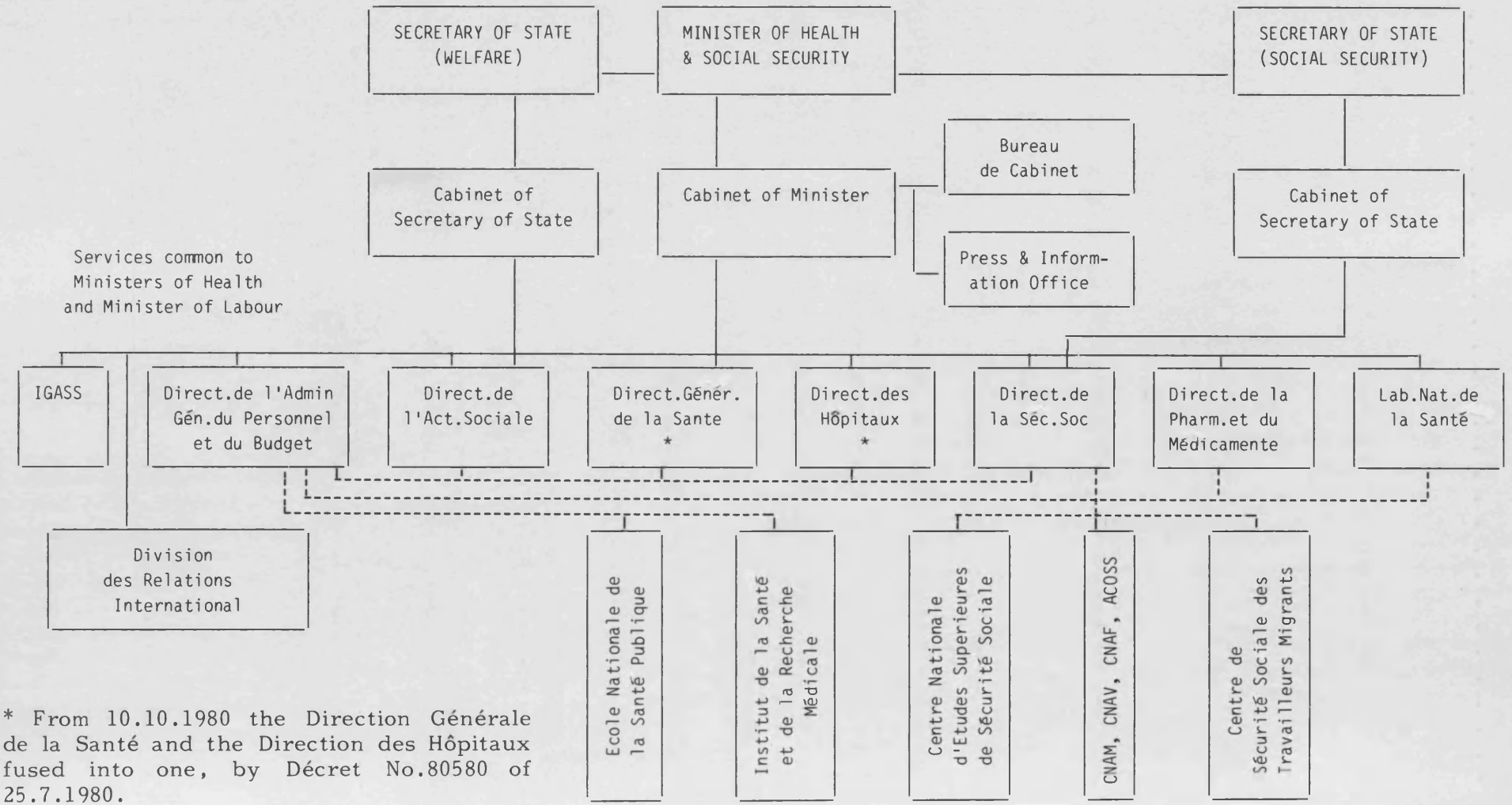
minority.[14]

The 1958 constitution produced a number of significant changes in the political institutions of the country, but the administrative system remained largely unchanged. The formal pyramidal structure of Ministries can be seen in the 'organigramme' of the Ministry of Health on page 13. Such diagrams are common features of legal textbooks, but unfortunately they tell us little about the way in which policy is made. In common with other Ministries, the Ministry of Health is made up of a number of 'directions' each divided into different services, which are in turn made up of numerous bureaux. Attached to each Ministry are a number of advisory councils, committees, and commissions. Hayward describes French Ministries as 'compartmentalised aggregation of divisions which are themselves confederations of autonomous bureaux'.[15] This administrative system is characterised by poor communication, both within and between Ministries. That the system functions at all, it is argued, is due to the role played by the 'Grands Corps', whose members occupy the top posts in all Ministries. Hayward describes the 'Grands Corps' as the 'agents du changement par excellence', and argues that their 'common social and educational background, culminating in an organisation into exclusive corps, has created a distinctive type of public official who commands both specialist skills and a general all purpose competence'.[16]

The apparent importance of the 'Grands Corps' has attracted much attention. Research on the common social and educational backgrounds of the members of the 'Grands Corps' has highlighted a number of interesting features of this 'cast'. Darbel and Schnapper have shown that only 5.5% of the 'Grands Corps', 'corps de contrôle', and technical

Organigramme of the Ministry of Health

(Source: Indicateur Statistique, CNAMTS, Paris, 1980)



* From 10.10.1980 the Direction Générale de la Santé and the Direction des Hôpitaux fused into one, by Décret No.80580 of 25.7.1980.

corps are the offspring of members of the 'popular classes', and that 76.5% of the 'Grands Corps' have 'upper class' origins.[17] Lalumière has shown that over an eighty-five year period, approximately 40% of 'Inspecteurs des Finances', one of the most prestigious of the 'Grands Corps', came from four Paris 'arrondissements'. Family tradition has also been shown to be of critical importance. Over the same period, the most significant correlation between entry into the Corps and father's occupation was with 'haut fonctionnaire'.[18]

According to Jane Marceau, the major beneficiaries of the creation of the 'Ecole Nationale d'Administration' (ENA) have been the children of the petit-bourgeoisie. She argues that post 1947, (the ENA was created in 1945), two thirds of the sixty eight 'Inspecteurs des Finances' recruited through the ENA have come from the haute-bourgeoisie, and that 27% have come from artisan and commercial families.[19] Marceau argues further that this domination of the civil service by a certain class is not significant on its own, but that it is repeated in the National Assembly, the Senate, the Government, and in public and private industry.[20]

The assumption behind this approach to the French higher civil service is clearly stated by Marceau. She argues:

> That by examining the social composition of and recruitment to institutionalised power positions, one may deduce at a secondary level, if not necessarily in whose interests the system works overtime, and overall, who at least has the greatest probability of access to positions which seem to carry the most weight in the making of public decisions in the widest sense of the word.[21]

If this deduction is to be of any value, then the institutional power

positions must effectively be powerful, and the common educational background of the higher civil service should have common observable outcomes. This is by no means evident. The domination of the élite of the higher civil service and public and private industry is by no means unique to France. It is therefore worth asking what if anything the class and educational background of the élite tells us about the policy process.

Suleiman has questioned the basic assumption behind the approach. While confirming the above analysis of the social and educational background of the French bureaucratic élite, he argues that this does not allow us to deduce that the bureaucracy is powerful or alternatively subservient to sectional interests. In his view, the reality is far more complex. According to Suleiman, 'The relationship between background and character cannot simply be assumed from the socio-economic status of those who occupy élite positions in society'. According to Suleiman, conflict exists between and within the corps, and the role played by the higher civil servant is as, if not more, likely to affect his behaviour as his class background or corps membership.[22] Wright also rejects the concept of the administration as a cohesive unit defending specific interests. He points out that conflict between Ministers competing for scarce resources is inevitable, and argues that the 'Grands Corps' are not immune from this type of conflict, as evidenced by the frequent differences between corps. Like Suleiman, he argues that 'attitudes amongst top civil servants <u>do</u> differ, and one of the determining factors is the function or role they perform'.[23] Thoenig provides an example of this kind of conflict in his analyses of the corps of civil engineers, the 'Ponts et Chaussées', responsible for road building and maintenance.[24] Suleiman concludes that, rather than class interest, 'the commitment

of the élite is to the health and well-being of its corporate organisation, rather than to a set of policies. Policies are looked upon as a means of enlarging a corps domain, or leaving it unchanged, or of reducing it'.[25]

Whether or not the social and educational background of the 'Grands Corps' is an important factor in determining the behaviour of corps members, it is clear that the 'Grands Corps' play an important part in the policy process. Hayward points out that in 1971, 90% of the members of Ministerial cabinets were from one or other of the 'Grands Corps'. Ministerial cabinets are responsible for both the formulation of policy proposals, for advising the Minister on policy options, and supervising the implementation of policy. The senior post in the administration, that of 'Directeur', is also reserved for members of the 'Grands Corps', and the various policy making bodies like the 'Commissariat du Plan' and the 'Délégation à l'Aménagement du Territoire et à l'Action Régionale' (DATAR) are staffed by members of the 'Grands Corps'. The 'dirigiste' traditions of French government further increases the importance of the policy role of this group. Since Colbert, the French State has always intervened in a wide range of affairs. According to Hayward, 'The weight of this long standing 'dirigiste' tradition still makes itself felt in the sense of dependence upon government which French businessmen more or less publicly acknowledge'.[26] The 'Grands Corps' are the inheritors of this tradition. They believe that it is the duty of the State to intervene to promote the general interest, and their training is geared towards this eventuality. They are also perceived by the business community, by lower ranking civil servants and the public in this light. Stevens writes, 'The part played by the higher civil service in economic policy making is thus important, at least in

part, because it is expected to be important'.[27]

However, there is some evidence to suggest that the influence of the corps varies from Ministry to Ministry. According to Hayward, a clear but unwritten pecking order of Ministries exists, with at the top the most prestigious Ministries of Finance, Foreign Affairs and the Interior, and at the bottom, Health, Transport and Culture.[28] The most highly qualified graduates from the ENA, and ambitious young corps members seek out positions in the former, not just for prestige but also for the more attractive salaries available. One result of this may be, as Darbel and Schnapper point out, that 'It is in the social ministries (14%) and education (18.5%) that the fraction of higher officials from working class origins is highest'.[29] This suggests that in a Ministry like Health we might expect to find the influence of the 'Grands Corps' to be less pervasive.

Another factor which tends to support this supposition is the nature of the policy involved. The strength of the 'Grands Corps' is derived to a certain extent from the fact that their members are generalists, able to adapt and understand the policy requirements of any policy area. In the field of health, however, they are dealing with the medical profession, who in their own way form a corps united by common social and educational backgrounds. One of the uniting principles of the corps is their belief in the special nature of the product they provide, and the principle that peer review is the only acceptable form of supervision of medical activity. In view of this one might expect to find that the health policy area is either a battleground between two corps, or alternatively that the administrative élite have abdicated responsibility to another corps. If this is the case, how can it be explained? Is 'dirigisme'

only accepted in the domain of economic and industrial policy and not, for example, in the field of health? If so, what are the consequences for the way health policy is made?

A second question relating to the role of the 'Grands Corps' as policy makers is what form their policy making takes. In chapter 2 I will argue that policy making is a complex process which involves more than just the identification of problems and the evaluation of policy responses. If the 'Grands Corps' play a policy making role only in the sense outlined by Selfe,* that is as rational planners, and the detail and donkey work of policy formulation and implementation are beyond their responsibility, then their contribution to the process as a whole may be less significant than has previously been maintained.

Another theme common to the literature on the French Administration but with general relevance is the control or lack of it exercised by the Executive over the Administration. During the IVth Republic the instability of governments meant that the Administration was to a large extent responsible for not only implementing policies, but also for formulating them. The Vth Republic has produced stable governments, but the scope of government has increased, as has the complexity of policy problems while parliament's ability to control government has decreased. During the seventies the growing politicisation of the Administration, with the bureaucracy becoming increasingly Gaullist, then Giscardian, has led some analysts to suggest that the bureacracy was no longer a neutral instrument of government, and that it had been colonised by particular interests.[30]

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* See chapter 2.

According to Wright, despite the fact that 'certain civil servants exercise a discretion which borders on the autonomous exercise of power', the model of the Vth Republic as an administrative State must be qualified.[31] He argues that the founders of the Vth Republic were not only intent on strengthening the Administration, but also in ensuring its subordination. Suleiman's viewpoint is slightly different. He argues for the need to distinguish between Government stability and Ministerial stability. While the former has been the case in France during the Vth Republic, the same cannot be said of the latter. Thus, in his view, Ministerial control over the civil service is mainly due to the existence of coherent governments that could not collapse as a result of disagreement on some particular project. Suleiman argues, 'Administrative or Ministerial stability has not varied very much between the IVth and Vth Republics, what has drastically changed has been the party structure, so that there exists in France today a 'Party Government' in Richard Rose's sense of the term'.[32]

It would seem reasonable to assume again that the degree of Ministerial stability varies from Ministry to Ministry. Thus the Minister of the Interior is unlikely to be changed frequently. In addition it seems reasonable to assume that the personality of a Minister is an important factor influencing the relationship with the Administration. An important political personality in a prestigious Ministry is likely to be anxious to make his mark in Government and will be more likely to do so as he will attract the most highly qualified and ambitious members of the 'Grands Corps'. A minor Ministry may be a convenient backwater in which to place a loyal, but less brilliant collaborator, or a stepping stone for a young less experienced politician. In this type of Ministry, instability rather than stability would seem to be the rule. An observation

by Wright tends to support this hypothesis. According to Wright, the relations between the Minister and the Administration differ according to the policy area and the quality of the Minister. Thus he argues that 'a skilful Minister will always get his own way even over a powerful Administration'.[33] This poses the question, what are the likely policy consequences of this for the Ministry of Health? Or put in another way, does there exist an independent health policy within the Administration in conflict with that of the official policy of the Minister?

1.iii. **Local Aspects of the Central State**

French local government and administration can be approached in a number of different ways. The field was for long dominated by administrative lawyers, whose aim by definition was limited to describing the formal aspects of the institutions. This has led to an emphasis on centralisation, and the power of the Prefect. However, recent critics of this approach have pointed out that legal regulations are by nature negative; they describe the obligatory functions of the local unit, and what can and cannot be done, but they do not account for informal process, and the important scope for manoeuvre in the areas not regulated by the State.[34] Most importantly however, the legalistic approach is concerned with theory and not practice, and thus ignores the vital importance of human relations, in other words politics, in central/periphery relations. (Detton, for example, provides a useful starting point for more detailed research into the reality of the administrative process)[35]

A second approach described by Machin and Wright as 'opportunistic' can be seen in the writings of those actually involved in the system, such as local 'Notables', Prefects, and national politicians, who according

to the above have the Machiavellian characteristic of admitting in private that affairs are more complicated than their publications would suggest.[36]

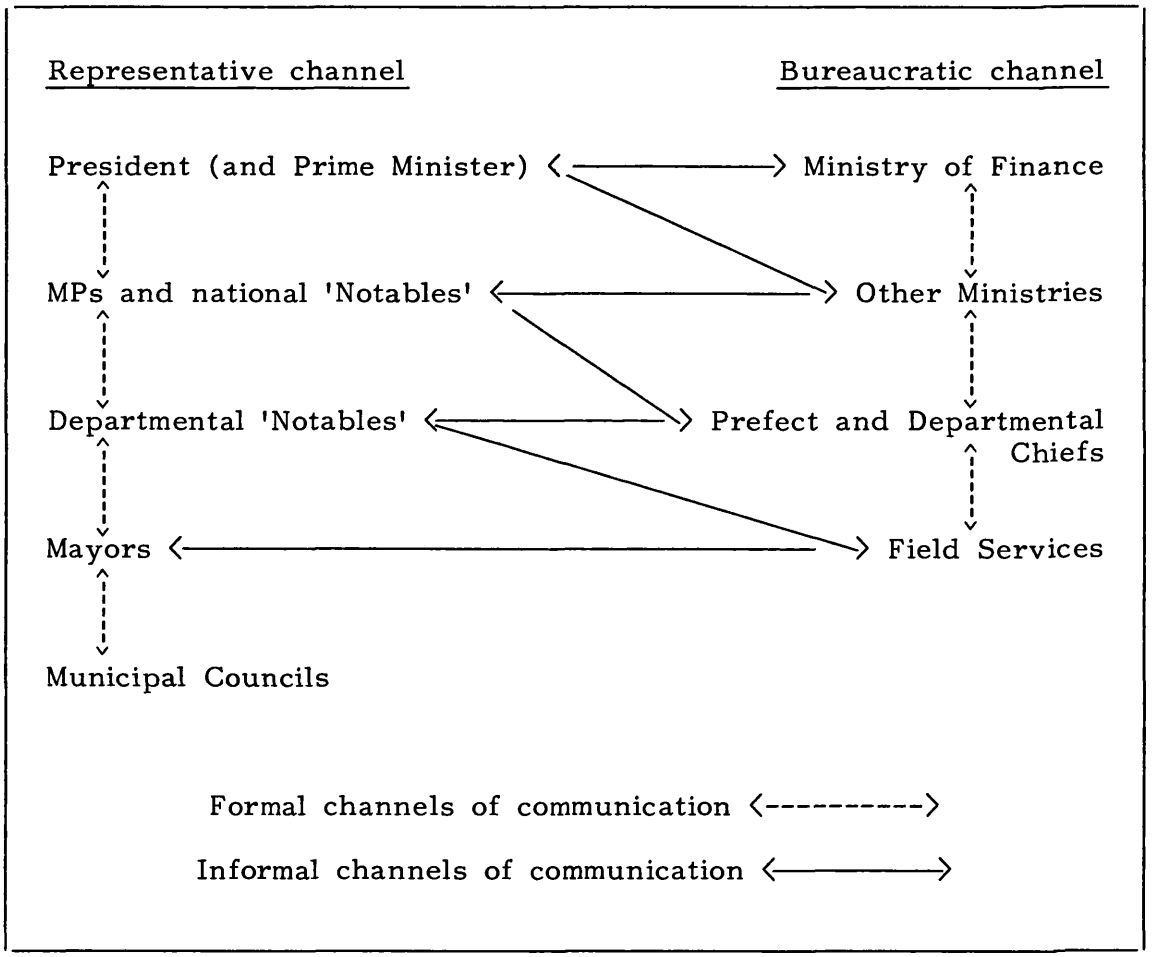
A more political approach has been adopted by those who argue that the State has become over centralised, and the existing structures dysfunctional. This contention has been justified in two different ways. Firstly some have based their arguments on a critique of the efficiency of the State, like the 'technocrat' J.Monod, who has drawn on his experience of the planning process, and as head of DATAR, in order to argue for the decentralisation of real decision making power to the regions, backed by financial independence.[37] Secondly, authors like J.J.Servan Schreiber, and Edgar Pisani, have combined criticisms of the efficiency of the present structures, and their undemocratic nature, in support of local administrative reforms. Supporters of the various regional movements have argued for the need for decentralisation on the basis of the cultural specifity of their regions. The more extreme version of this can be seen in the actions of the Breton and Corsican nationalists.

All the above share the initial assumption that France has a rigid centralised administrative system dominated by the Paris bureaucracy. However, recent research has qualified and even questioned the validity of this assumption. The Crozier school of sociologists have convincingly argued the existence of a complicated network of relations characterised, not by the domination of Paris, but by the interdependence of actors.[38] Comparisons between rural and urban areas have suggested that a new style of local government is developing,[39] and party politics has been shown to influence the way local government performs.[40] The result is a picture of central local relations far more complex than that which

'which are that much more efficient as a result of being only half conscious'.[43]

With Thoenig, Crozier has developed a model of what they call the 'power relations in a parallel system'. The key figures within this model are the prefect and the mayor. According to Crozier, the decision making process within this system is neither hierarchic, nor contractual, but 'un processus croisé ou en ziz-zag particulièrement bien adapté à un modèle d'évitement des responsabilités'.[44]

Plan of the Model of Criss-Cross Regulation



(Adapted from Jean-Claude Thoenig, State Bureaucracies and Local Government in France, Berkeley, California, Dept of Political Science, Mimeo, March 1975) p36)

existed previously. This complexity is well expressed by Machin, who writes, 'Power has traditionally been distributed between Paris and the periphery, and groups in the periphery, in such a complex way that any systematic model of local government is inevitably more misleading than revealing as a guide to what happens at any given moment in any particular policy area'.[41]

Crozier's work on French local government was a logical continuation of his work on the French administrative system which resulted in the publication of the now classic 'Le Phénomène Bureaucratique'. Crozier's understanding of French local government is strongly influenced by the theories developed in this book. Here the particular structure and practices of the French civil service are explained in terms of 'cultural traits' peculiar to the French, and in particular what Crozier terms their 'fear of face to face relations', which results in the creation of formal or informal mechanisms for avoiding confrontation.[42] Thus within the local government system, Crozier distinguishes (see diagram on p.23) two separate channels of communication, the one administrative, and the other political, made up respectively of Ministers, Prefects, and the field services, and the Deputies, Mayors and other locally elected officials.

This system according to Crozier is characterized by the poor communication that exists within each channel, which results from the above mentioned fear of face to face relations. Despite the fact that the system generates a large amount of dissatisfaction, the frequent attempts to reform it have failed. Crozier argues that this dissatisfaction is in fact part of a complex strategy employed by the players in the complicated network of relations with a hidden logic and informal rules,

In this criss cross model, vertical communication is poor, and regulation is achieved by each individual group resorting to the arbitration of another group in another channel. The phenomenon of the 'cumul des mandats' which allows mayors, for example, also to be elected as departmental councillors, deputies or even government ministers, facilitates communication within channels and confers exceptional powers on the holders. The system is centralised according to Crozier, but he argues that the power of Paris is nevertheless limited. Thus he argues that while all decisions may be made in Paris, they are not necessarily made by Paris. The vital element in this system is the access to information. According to Hayward, 'The field services, who have the necessary information, cannot decide. Their superiors in Paris could decide, but lack the necessary information, control over which allows the field services to preserve a measure of autonomy'.[45]

According to Crozier, it is through the criss cross system that demands and pressure are channelled to the centre. A mayor is judged in terms of his contacts within the administrative channel, and the 'goods' which he is able to deliver as a result. Despite its complexity and apparent arbitrariness, Crozier argues that the system has some advantages. It is more human, and less rigid than the formal structure leads us to believe. It allows for a certain degree of local autonomy and participation. Most importantly however, in Crozier's view, is that although the system is oppressive and authoritarian, this is anonymous oppression and impersonalized authority.

The disadvantages of the system according to Crozier, are that responsibility for failure is continually shifted upwards by the actors. Success on the other hand is highly personalised. The system also

encourages conservatism. Mayors tend to take the lead from Paris and the Prefect about what kinds of projects are likely to be approved in official circles, rather than base their demands on the needs of the community. This explains for example the flowering of municipal swimming pools all over the country in recent years. Finally the system tends to exclude certain communes, and to favour others. Thus, according to Crozier, 'On pourrait presque dire que le système existe pour dispenser des exceptions à ses propres règles'.[46]

In an elaboration of this model, Crozier and Thoenig distinguish three different sub-systems. Firstly the rural commune, the most common case in terms of the overall number of communes, but representing a decreasing proportion of the population. The second variant is the 'Maire cumulant', the Mayor who is also a departmental councillor or a Deputy, a frequent occurrence. And finally, the Mayor of a large town. This group represents a comparatively small number of communes, but an increasingly large proportion of the population. The 'Maire cumulant', and the Mayor of a large town, are in a far stronger position than the Mayors of rural communes. The Mayor of the large town has a certain political prestige, and his own administrative and technical services, and is able to overcome the poor communication between channels and within the administration, by dealing direct with Paris. The 'Maire cumulant', depending on the nature of his second mandate, is able to straddle different levels within the various channels of communication and thus overcome the poor communication.[47]

Another member of the Crozier school has added detail to this model. J.P.Worms has described the relationship between the Mayor and the Prefect, illustrating what he calls the 'phénomène du couple', or in other

words the complicity and interdependence of the two.[48]

Mark Kesselman, in his study of French rural mayors, presents a slight variation on this theme. According to Kesselman, the Mayor dominates his municipal council and is seen by the electors as incarnating the general interest of the commune. Like the above he identifies the same complicity between the Mayor and the Prefect, and argues that 'The characteristic pattern of ostensible unity existing alongside masked cleavage' is likely to remain a feature of French local government despite the growing threat to consensus represented by the increased demands being placed on local government.[49]

The Crozier school's contribution to research on local government in France has certainly been considerable. The importance of informal networks, and informal processes, no matter how difficult these are to uncover, and to document, has been strongly argued and provides a far more satisfactory explanation of the reality of the system than the traditional administrative science textbooks. But how satisfactorily can policy be explained in these terms, and what form do the informal networks take in the field of health where two important new sets of actors, the medical profession and hospital administrators are involved? If in the health field the same sort of informal system does not exist, can this be explained in terms of the nature of the health policy field, or do we need to re-examine the assumptions behind the Crozier model? Our analysis of the implementation of policy for general medicine and hospital care in the Rhône-Alpes Region is intended to provide some of the answers to these questions.

However, the arguments and methodology of Crozier's 'Le Phénomène

Bureaucratique' have now been cogently criticised by Roger Duclaud Williams. Duclaud Williams rejects Crozier's 'nationally typical model of social relations', and argues that the theory he puts forward 'are too general to be capable of attracting any useful answer'. While recognising that certain general cultural features may explain the success or failure of a given reform or project, he argues that 'there is a world of difference between doing this and presenting a model which purports to explain phenomena which vary from revolutions and coups at one extreme to congested Post Office Savings Banks at the other'.[50] Duclaud Williams has also made a powerful argument for a policy based approach to these same questions. In Duclaud Williams' view, in analysing change in society, it is necessary to identify the obstacles to change, which he believes are likely to vary according to the policy arena. He concludes therefore that we are likely to get closer to finding a more satisfactory general theory and explanation of change by comparing and contrasting policy arenas.

A policy based approach to the literature on central periphery relations in France generates another criticism of the literature. Much of the research in this field has concentrated on analysing the various reforms of local government in France during the sixties and seventies. It is worth asking whether this analysis tells us more about the specific policy arena of administrative reform, or about relations between the centre and the periphery in France.

An example of the dangers of this approach can be seen in Douglas Ashford's comparison of French and British local government. Ashford writes that 'despite the centralising aspirations of the French national government, the dispersion of political power in the French communes,

and the complexity of the administrative system, may have given the communes more effective influence over national decisions' than their British counterparts.[51] However, his evidence for this claim is drawn largely from an analysis of the various administrative reforms in France and Britain. It could be argued that such a conclusion applies only to administrative reform and reflects the significantly different distribution of administrative personnel between the centre and the periphery in France and Britain.

Some evidence exists to suggest that a policy based approach to local government in France would be worthwhile. In his analysis of the municipalities of Nimes and Montpelier, two towns controlled by different political parties from opposite ends of the ideological spectrum, J.Milch found significant differences in the form of decision making and the content of policies. This suggests that local governments do have a certain degree of autonomy, but also, as the differences existed only for certain policies, that the degree of autonomy varies from policy to policy.[52] Roger Duclaud Williams' analysis of the politics of housing in Britain and France is another example. He argues that one of the crucial factors determining innovation in this policy area are the relations between government and housing authorities, and government and the financial institutions involved in the housing market.[53]

The question posed here is how does the process of the making and implementation of health policy confirm or contradict the accepted model of centre periphery relations in France, and if it differs, is this difference due to the particular nature of the product health, or does it suggest that the model is inaccurate?

1.iv. Interest Groups

The same questions can be asked of interest group activities in the field of health in France. Does the form taken by the activities of medical interest groups conform to the general model of interest group activity in France? Is it determined by the institutional structures, and the generally accepted ideas about the role of such groups in France? If it differs, how can this be explained?

To answer this question one must first determine the dominant pattern of interest group activity in France. Until relatively recently this area of French politics has been neglected by analysts. This is explained by the fact that most students of the French political system have tended to accept the view, propounded by politicians and civil servants, that the centralized state regards itself and acts as the guardian of the public interest and sees interest groups as divisive forces with no place in the decision making process. Thus according to Suleiman, 'Students of French politics, having accepted the philosophical beliefs concerning intermediary groups as an accurate reflection of the actual political process have not found it necessary to examine the influence that groups do play in the French political system'.[54] Suleiman argues in contrast that the role of interest groups can be seen on two levels; the philosophical and the empirical, and that the former has been stressed at the expense of the latter.

Evidence of this lopsided approach is seen in the literature which can be divided into three broad categories. In the first the emphasis is on listing and categorizing the different groups in French society, and with broad general hypotheses on their influence. Jean Meynaud is the best known of the authors in this category, but while his work

is useful as a guide, he does not analyse the interaction of interest groups with the political system, or explain how groups influence or fail to influence the policy process.[55]

The second category is made up of the large number of case studies of specific groups within the Trade Union movement, business organisations, or agricultural pressure groups in France. Once again the emphasis is on describing the organizational structure of the various groups, their membership, and the ideological differences that divide them, rather than on the nature of interactions between these groups and the bureaucracy, the political parties and the government.[56]

Where studies of interest groups do relate to specific policies, the third category, these tend to concentrate on what Suleiman describes as 'explosive issues', like state aid to church schools, or the activities of the alcohol lobby. This type of analysis tends to focus on the heart of the battle, and seeks to identify a winner and a loser. However, because of the nature of the policies concerned it tells us little about the day-to-day interaction between groups and the state over issues that are not the subject of zero-sum conflict, surely the most common.[57]

In recent analysis the assumption that interest groups have little scope for influencing policy decisions in France has been questioned. Hayward, pointing to the large number of official and semi-official consultative groups that now exist alongside the administration, argues that 'the traditional distinction between advice and decision making is not erased, but blurred'.[58]

However, Hayward also maintains that the nature of relations between

interest groups and the State is still affected by the traditional French attitude to authority, which explains the sometimes violent turn their actions take, and why they only appear to be consulted during moments of crisis.[59]

Vincent Wright suggests that the increasing importance of the Administration in modern governments has not only led to an increase in their potential power, but has also increased their dependence on pressure groups for advice, and feedback on the impact of their policies.[60] Wright also argues that 'they (interest groups) are now the principle partners of the civil service in decision making'. However, as with other issues in French Government and politics, Wright is reluctant to speculate on the nature of this influence, beyond concluding that none of the four models of interest group activity - two commonly used, two relating specifically to France - is entirely satisfactory, but that each contains an element of truth.[61]

Using a very similar classification of the different models of pressure group activity, Frank L.Wilson has attempted to assess their appropriateness empirically, using a questionaire to elicit the attitudes of interest group activists. Like Wright, Wilson found that no single model corresponded completely with the attitudes expressed by interest group leaders. However, he does argue that certain models seem to be closer in reality than others. Thus, according to Wilson, there is little evidence of attitudes in support of the neo-Marxist model, even from those groups which openly profess a Marxist philosophy. Nor does he find much evidence in the attitudes of interest group leaders which supports the protest model of State/pressure group relations. According to Wilson, 'The predominant pattern of attitudes is pluralist'.[62]

Where Wilson focuses on the attitudes of interest groups towards government, Suleiman seeks to elucidate the attitude of the bureaucracy towards interest groups. He also attempts to explain how groups exert influence, and why some are more successful than others. According to Suleiman the cabinet and the Ministers have increasingly become the target for interest group activity, and the administration is more receptive to interest groups seeking to influence decisions at all levels. However, Suleiman argues:

> It is those groups which lack a permanent contact within the administration that attempt to influence particular policies by seeking different targets. The groups that have established close relations do not disperse their influence... On the contrary, for these groups pressure for or against particular policies is a constant and never ending process. They are engaged not in a fight to secure a once-and-for-all gain, but in a continuing attempt to affect the allocation of resources - or the distribution of power - in their favour.[63]

Suleiman's most important conclusion is that the Administration distinguishes between what he calls 'legitimate' and 'illegitimate' groups within French society. According to Suleiman, 'while the administration is theoretically equally open to all interest groups, in practice very careful distinctions are made among them'.[64] The basis of this distinction is the different attitudes held by bureaucrats towards 'interest' or 'pressure' groups, and what are termed 'professional organisations'. The difference between the two is subtle. An interest group is seen as being unrepresentative and of seeking the limited and selfish interests of a section of society, and hence as a challenge to the civil servants' duty to serve the 'general will'. A 'professional organisation', by contrast, is not seen by civil servants as a sectional interest. Suleiman

quotes a civil servant who defines a professional interest 'as one that defends not a private, but a group interest'.[65] Suleiman himself rejects this, pointing out that there seems to be little logic in the distinction, and deduces his own definition from bureaucratic practice. He argues that each Administration decides for itself which groups to treat as 'professional', and hence with which groups to maintain close contacts. The most important criteria in this choice, Suleiman argues, is that the demands of the group do not conflict with government policies. Once a group is chosen by the Administration, Suleiman claims that very close clientele relationships are built up between government and interest group representatives.[66]

Suleiman's research is particularly relevant to the concerns of this thesis. In chapter three the importance of this issue to the field of health policy will be made clear. This overlapping of issues provides an ideal opportunity to investigate whether the particular characteristics affecting a specified policy area, or more general factors, applicable to a political system as a whole, are more relevant as explanatory variables of a given situation.

The main body of literature on interest groups activity in France would seem to suggest that the influence of the medical interest groups on health policy is likely to be minimal, as a result of the unrepresentative and divided nature of the groups representing doctors' interests. On the other hand, on the basis of Suleiman's theories, one might expect to see evidence of close cooperation between medical interest groups and the Administration, with the former exerting a significant influence on policy decisions. The medical profession could be given as a classic example of that rather vague category, the 'professional organization'.

They constitute a clearly identifiable professional group which is in turn very conscious of its identity, and which is in general highly regarded. The profession is not noted for its radicalism, and the social and educational background of its members is very similar to that of their interlocutors in the bureaucracy. The function they perform is highly technical and specialised, giving them control of information vital to policy makers. Medical ethics, which stress the doctor's overriding duty to his patient, have the same moral overtones as the State philosophy of the general will. For all these reasons one would expect the medical interest groups to be natural and accepted partners of government.

1.v. **Planning Policy**

At the beginning of this chapter I argue that an institutional based approach dominates the literature on French government and politics, and that little or no attention has been paid to policy. This requires some qualifying as, in the first place, a cursory survey of the literature will show that planning policy has for long attracted considerable attention.[67] More recently, a number of researchers have addressed themselves to specific policy areas, or the issue of policy making in general.[68]

The policy area that has attracted the most attention from analysts, both inside and outside France, has been French planning policies. The reason for this was the apparent success of planning policies in the sixties. Many analysts attempted to understand French planning in the hope that they would find the magic 'elixir' of economic success. In other words their aim was to recommend better policy. The relative failure of the Plan during the seventies, and the declining importance attached to it by the new political élite, has led to a reassessment of

the importance of the plan.[69] However, the emphasis has tended to be on the institutions of planning policy or the content of policy, and not on the policy process. In some cases the concept of policy is taken as given, and not defined.[70] An approach to planning or other forms of policy making in which the concept is defined and analysed might suggest possible alternative explanations of the same issues. As an example, planning may have been an ardent obligation for de Gaulle, but may also have been used by the Giscard/Barre government as a way of financing less ambitious priority programmes (the 'PAP' or Priority Action Programmes). In both cases the rhetoric of planning may be a classic example of symbolic policy making. Another insight suggested by a policy approach is, as Self has pointed out, that planning is only one type of policy making, and a rather special type at that.[71] Thus the authors describing the planning process in France have not consciously addressed themselves to the issue of planning as a particular policy, but rather have been attracted to planning as a particularly interesting policy.

Of the recent research dealing with particular policy areas, or public policy in general, the tendency has been simply to describe different policy areas rather than to analyse the policy process. In the introduction to 'French Politics and Public Policy', edited by Philip Cerny and Martin Schain, the authors declare the aim of the anthology to be to 'describe and analyse the workings of the French State, without adopting the biases of either the institutional or administrative focuses that have tended to dominate the literature on French government'. Rather they argue that this artificial division 'has tended to obscure the complexities of the political process in France, particularly the links between inputs and outputs'.[72] However, the structure of the book

betrays these intentions. Although one of the initial observations of the authors is of the 'general lack of influence of party organizations on the Vth Republic'[73], the first two chapters describe the French party system. Other chapters deal with the predominance by the Parisian middle class of the members of the higher civil service, but not how this translates into policy.

Where substantive policy areas are looked at as in part two, there is no definition of policy to serve as a common thread, and hence no possibility of drawing any relevant conclusions about the similarities and differences of the policy making process in different areas.

1.v. Conclusions

From the above the necessity for a new and different approach to French government and politics is clear. The traditional institutions based approach has come up against the brick wall of complexity and the conflicting evidence of the reality of a large and highly sophisticated political system.

Faced with this problem, researchers have called for a policy based approach to the subject to avoid the biases of existing methods. A starting assumption of this thesis is that a policy based approach can contribute to our understanding of the French Political system, but that an essential prerequisite for the success of this approach is clear definitions of the term, used consistently.

The literature on policy and policy analysis discussed in the next chapter deals extensively with the definition of the term and the important concepts used in connection with it.

Chapter Two

POLICY MAKING AND POLICY IMPLEMENTATION

2.i. Introduction

The concept of 'Public Policy' is a relatively new one which in recent years has attracted increasing attention. New journals have flourished, and the use of the term has become more and more common. However, like all new concepts, it is used and abused. Public policy is concerned with what governments do and the effect of their actions on the target population. While this concern existed long before the term was coined and will continue to be one of the fundamental issues concerning political scientists for a long time to come, the emergence of 'Public Policy' or 'Policy Science' as a separate discipline has grown out of the neglect by political scientists of this aspect of government activity.

Three reasons for the emergence of a body of literature concentrating on policy can be identified. One of the main justifications for this approach is the need for 'theoretical comprehensiveness'. Thus put in terms of Down's input-output model of government, the dominance of the behaviouralist school has resulted in an emphasis on 'input', or in other words the role of political parties, interest group activity, and electoral behaviour to the exclusion of output.[1] This approach assumes that policy is a product of these factors, but, policy analysts argue, by concentrating on inputs it fails to adequately show the linkage between these 'inputs' and policy 'outputs'.

A second factor explaining the emergence of the concept of public policy is a result of a combination of increasing demand from government

for information and advice on specific policy problems, and the increased supply of political scientists willing and anxious to be 'useful'. The increasing scope of government during the seventies, especially in the fields of welfare and unemployment policies, coincided with what has been termed the problem of 'ungovernability', or the seeming inability of decision makers to design and implement policy programmes which satisfy politicians and meet their objectives. Particularly in the United States, academics have been commissioned to study the impact of government programmes, or recruited into government as participants in the process. This has produced two different approaches to studying policy. On the one hand those analysts who seek to recommend better policies and, more importantly, better ways of making policy. On the other hand, those who have brought from their practical experience a realisation that the traditional explanations of how governments work and of how policies are made are a long way from reflecting reality.

Thus the third factor explaining the development of public policy literature was public policy itself. Policy, it is argued, is intrinsically interesting and unexplained. Theorists here are interested in understanding the simple question, 'how do policy makers decide?' The level of analysis ranges from the study of micro policy decisions, like the siting of an airport, to macro studies in a substantive policy area like health, or more abstract concepts such as distributive policy. The unit of analysis ranges from the single bureaux within a country's administration, to the bureacracy and the political process as a whole.

The search for a better understanding of how the policy making process works, and the desire to be 'policy relevant' have also encouraged the development of comparative policy. Although comparative analysis

predates the renewed interest in policy making, it has been given a new dimension by policy analysts. The traditional form of comparison tended to be little more than a description of the different institutions and practices extant in various countries. This involved contrasting party systems or institutions, or in the case of policy, describing the content of policy. Little or no attention was paid to the nature of what was being compared, or to the methodological problems of comparison. Where attempts are made at explaining differences in policy, cultural factors are usually given as the key criteria. Thus for example the absence of a national health service in France is explained by Ridley and Blondel as the result of 'a long standing suspicion of government bureaucracy'.[2]

One might justifiably claim that 'a long standing suspicion of bureaucracy' exists in a number of countries which do have national health systems, and that therefore this explanation is incomplete, if not invalid. Nevertheless, this type of analysis is a useful and necessary grounding for any comparative study as it provides rich detail on the institutional and structural features of the society in question, on the basis of which comparisons <u>may</u> be made.

In contrast, comparative policy analysis seeks to explain policy. For the analyst seeking to be 'policy relevant', comparison is a way of learning from the experience of other countries. But for these lessons to be valid it is necessary to identify and evaluate the numerous factors explaining policy output, and influencing policy performance. For the policy analyst attempting to understand how the policy process works, comparison provides the closest equivalent to the conditions of scientific experiment. Comparisons across nations allow analysts to formulate

and test hypotheses about the effect of factors like ideology, party system or dominant values on policy making and policy output. However, the very exercise of comparison has revealed the extreme complexity of the decision making process and the enormous methodological problems involved in comparison.[3] This methodological discussion forms an important part of the policy analysis literature.

2.ii. **Defining Policy**

Before any attempt can be made to analyse policy, it is necessary to define the concept. A major part of the literature on public policy is concerned with the methodology involved in analysis, and thus a number of definitions have been developed for this at first sight self-explanatory term. The simplest definition of policy is 'what governments do'. However, this begs a number of questions. Is 'policy' what governments say they are going to do, or what they do in practice? How does one identify policy? Is policy limited to government legislation and the rules and regulations laid down by the administration, or can it be isolated by the analyst on the basis of all three of the above? Is policy the declared aim of government, or the results of the implementation of measures in pursuit of policy objectives? From the above it is clear that the definition given of the term plays a large part in determining the questions that will be asked and the explanations provided by the analyst.

In the Oxford English Dictionary 'policy' is first given its original sense, equated with polity, and politics. A second definitional sense suggests 'prudence, skill, expediency, statecraft, and diplomacy', as well as 'political cunning, a prudent or politic course of action, or a stratagem'. The fifth sense, described as the main modern usage, defines

policy as:

> 'A course of action adopted and pursued by a government, party, statesman, etc'.

The definitions provided by Webster are similar, but in the case of current usage, more detailed. Here policy is defined as:

> A definite course or method of action selected (as by a government, institution, group or individual) from among alternatives and in the light of given conditions to guide and usually determine present and future decisions.

Both the above definitions are acceptable for general purposes but both assume that the 'course of action' is purposive and self evident. For the analyst of Public Policy a more sensitive definition is necessary.

According to Jamous, one of the few French academics to have tackled this issue:

> Une réforme, ou une décision gouvernementale, est le plus souvent destinée à porter remède à une situation qu'on qualifie généralement de crise'.[4]

This 'crisis' approach to policy making (shared with Crozier) is not particularly helpful, as it either debases the meaning of the term 'crisis', or leads to a concentration on exceptional situations.

In his book on the Cuban missile crisis, Allison argues that foreign policy decision making has traditionally been explained by conceptualising the State as an individual rational decision maker out to maximise his objectives. As a result, foreign policy is described as a series of sequential events such as the signing of treaties, declaration of wars,

or blockades. These decisions are seen as being the product of rational consideration of the options available to government followed by the selection of the optimum course of action. Policy is seen as the sum of a number of decisions taken consciously by an organisation which is assumed to act in the same way as 'rational man'. Policy problems are identified, possible solutions evaluated, followed by decision. However, Allison rejects this conceptualisation of policy, arguing that while it may provide a rational explanation of a given event, it does not necessarily fully explain that event. Allison argues that even if one takes into consideration the qualification of rationality in, for example, the work of 'March and Simon', this is still an unsatisfactory approach. According to Allison this type of rational explanation of a particular policy is only possible on the basis of selected information available to the 'armchair analyst', and does not help us to understand how that policy is made. It is an explanation which, Allison argues, only explains 10% of the process, and the results of the decision in terms of policy outcome. Thus one of Allison's main points is that policy making and implementation are part of the same process, and that equal attention be paid to what he describes as 'the path between preferred solution, and the actual performance of government'.[5]

The Jamous crisis approach and the 'Rational Actor' model also illustrates the ambiguity of the term 'decision'. The concept of 'decision' fits neatly into the rational actor model of policy making, because it implies a neatly isolated, easily identifiable and purposive government action. However, as I illustrate in chapter six, while a policy may be rational, it may also be accidental, it is often contradictory, is continually evolving, and is not necessarily a response to an identified crisis. The concept of 'decisions' may have its intellectual logic, but in practice

it is only in the context of policy, or a series of decisions, that it has any meaning. Thus, according to R. Rose, 'Policy' involves more than decision making. He defines policy as a long series or more or less related activities and their consequences.[6]

Other writers also include 'decision making' in their definitions of policy, but only as part of a more complex process. Thus Etzioni sees policy as generalised decision making in which whole sets of decisions are considered, and the contexts for decisions reviewed.[7] Braybrooke and Lindblom define policy as decisions, 'and the course that policies take as a result of interrelation among decisions'.[8] These definitions all imply that policy and implementation are inseparable.

According to Heclo:

> Policy does not seem to be a self defining phenomenon; it is an analytical category, the contents of which are identified by the analyst, rather than by the policy-maker or pieces of legislation or administration. There is no unambiguous datum constituting policy waiting to be discovered in the world. A policy may usefully be considered as a course of action or inaction rather than specific decisions or actions, and such a course has to be perceived and analysed by the analyst in question. Policy exists by interrogating rather than intuiting political phenomena.[9]

This rather open definition has a number of points in common with those outlined above. Heclo argues that policy is purposeful: 'Policy is a course of action or inaction pursued under the authority of Government, intended to accomplish some end'.[10] Heclo also conceptualised policy as more than just the stated objectives of government, it must

also encompass the steps taken to achieve those objectives as well as the effects of these measures, whether intended or not. Thus Heclo argued that 'while policy is purposive, a statement of intent itself does not constitute the sum of policy', and that 'policy must embrace both what is intended and what occurs'.[11]

Like the above, Anderson argues that 'policy' implies both establishing 'intent' on the part of the government, as well as evaluating performance. He suggests four levels of analysis by which to establish the relation between intent and performance. These are: (a) overt action - or what policy makers say they are going to do in, for example, election manifestos or Government programmes; (b) Programmed resource commitment - the amount of resources actually committed by government in terms of budgets and planning documents; (c) Actual resource flows - the resources received by the implementing agencies; (d) Performance - the outcome of the policy, as opposed to 'output'.

Here Anderson provides, not a definition of policy, but rather what is probably more worthwhile, a practical way of delineating the content of the policy being analysed.[12]

Any analysis of policy must start by setting out what policy makers declare policy to be. This involves exploring the context of the policy, the policy makers' perception of the problem, and the wished for solution. However, as has been argued by Edelman, policy may be symbolic.[13] A useful test to distinguish between policies that are simply for show, and those which government has a real intent to implement, whether urgent or not, is to examine resource allocation in annual budgets or planning documents. This might also be a useful way of charting the

importance of particular policies over time. However, official budgets are an unreliable guide to what governments actually spend. In France, for example, the bulk of health care spending is financed by the Health Insurance Organisations, and as such is not part of the annual budget presented to the National Assembly. Secondly, spending is only one of a number of 'resources' available to government to achieve its objectives. Fiscal policy and monetary policy, to name but two means available to government, may be used as incentives or disincentives towards the achievment of certain objectives without appearing clearly in national budgets. The major weakness of this approach, and one that Anderson recognises, is the difficulty in measuring and evaluating resource flows and performance. For example in France, hospitals are financed by the State, National Health Insurance Fund, local government, and individuals. Determining the source and extent of increased resources to the hospital sector is an almost impossible task. Evaluating the outcome of increased resource allocation is an even more difficult and largely subjective issue. For example, increased government spending on hospital services may result in measurable increases in the ratio of hospital beds to population which would suggest that policy objectives have been achieved. Nevertheless in terms of 'performance' the policy might be judged negatively. How resources are allocated is also important. If they are spent on improving existing hospitals, then the policy will not improve the distribution of hospital services. If they are spent on sophisticated medical equipment, the 'outcome' may be marginal differences in morbidity statistics. An effective increase in the allocation of resources in a specific area is not then an entirely satisfactory measure of policy outcome, the evaluation of which depends to a certain extent on the criteria for measurement chosen by the analyst.

The minor differences apparent in the definition outlined above are overshadowed by the features common to all. It is clear that the term 'policy' is a broad concept consisting of a number of elements. Policy is action, or inaction, resulting from a series of governmental decisions and is purposive. It is a dynamic process in which means and ends are constantly changing. It cannot be considered in isolation from the process of implementation, and the effects of action or inaction on the target population.

In contrast to the above, Lowi defines policy in a more rigorous and abstract fashion. Lowi states that most government actions are a result of government policies, and the most fundamental government actions are policies. He then defines policies as 'rational exercises of political authority expressed as guidelines which seek to bring the actions of agents into some accord with the intentions of the governing élite'.[14] This is a highly abstract approach which Lowi himself admits excludes some of the aspects usually considered to be part of the policy process, but is designed to fit the author's categorisation of 'types' of policy. This categorisation has been highly praised for its theoretical rigour, but at the same time the value of this approach for policy analysis has been questioned.[15] However, Lowi has himself used his framework as a means for comparing French and American bureaucracies.

2.iii. **Lowi's Policy Categorisation**

Lowi identifies four categories of policy These are: distributive, constituent, regulative, or redistributive. He argues that, since the State is 'basically a cohesive force', these categories distinguish between the different types of coercion exerted by government. A distributive policy is made up of statutes which embody no rule, but set up a process

of delegation. Constituent policies lay down rules about rules. Regulative policies lay down rules of conduct and sanctions, and redistributive policy lays down rules about classification and categorisation. These categories are best illustrated in the matrix drawn up by Lowi, which includes practical examples of each.

Lowi's categorisation of Public Policies

	APPLICABILITY OF COERCION COERCION WORKS THROUGH	
	INDIVIDUAL CONDUCT	**ENVIRONMENT OF CONDUCT**
Remote (Indirect)	Distributive: these statutes embody no rule, only authorise a process or designate privilege. eg. Public works, Patronage, C19th US Land policies.	Constituent: these statutes embody rules about rules, or rules about powers. eg. Creating an agency, Admin reform, Electoral law, Budgeting.
Likelihood of coercion		
Immediate (Direct)	Regulative: these statutes embody rules of conduct, with sanctions. eg. Public Health Laws, Industrial Safety Laws, Anti Trust Laws, Food and Drug Laws.	Redistributive: these statutes embody rules of classification or categorisation. eg. Social Security, Graduated Income Tax, Monetary Policy, Low Interest Loan Programme.

Fig 1. Lowi's categorisation of Public Policies, from **Lowi, Theodore J.** 'Public Policy and Bureaucracy in the US and France' in **Ashford, D.** (ed) Comparing Public Policies, p179.

Lowi's contention is that 'each type of policy, when properly classified, will tend to be associated with a distinctive "arena of power" with its own characteristic political process and power structure'.[16]

Lowi argues that the Weberian model of bureaucracies, and the cultural variants developed from it have been misused by theorists in that they have assumed bureacracy to be unitary and have explained differences as the result of cultural phenomena. In contrast, Lowi claims that bureaucracies within a country differ in fundamental ways. He thus rejects the 'unitary model' of bureaucracies and proposes 'a concept of bureaucracies as specific mission orientated organisations'. Although there are certain common characteristics shared by bureaucracies, Lowi argues 'that each has a distinctive set of tasks to perform and the requisites for carrying these out will shape each organisation and its basic characteristics'.[17]

Using this conceptual framework, Lowi has compared the French and American bureaucracies with special attention to the role of the 'Grands Corps' in France. He presents a convincing illustration of the different roles played by the 'Grands Corps' in the different policy categories, and the similarity that exists to the pattern within the American bureaucracy. He shows that in both France and the USA the redistributive agencies are dominated by the highest level administrators and play a similar role, and that distributive agencies in the two countries are dominated by, in the case of France, the 'service technique', or substantive specialists in the USA. In other words, administrators whose power is a function of their technical expertise. This provides a useful antidote to the deterministic cultural model of the Crozier school. However it could be argued that this similarity is a product of the categorisation, and is only possible as a result of a high degree of abstraction which permits the author broad generalisations. The object of the exercise is to show similarities across nations, and differences between policies. This is achieved, but only at the expense of a formal categorisation

of policies into watertight compartments - something which does not reflect reality - and by a very generalised description of the roles of the various corps in French Administration.

Despite the very different approach adopted here, Lowi's research confirms a frequently stated theory on the role of the 'Grands Corps' in the French Administration. 97% of the 'Grands Corps' are in agencies with either constituent or redistributive functions. In other words the 'Grands Corps' are involved in essentially overhead functions, making rules about rules and supervising other administrative agencies staffed by middle and lower management.[18] This is a reformulation of Hawyard's description of the 'Grands Corps' as the 'agents du changement par excellence'.

Three important points however are illustrated by Lowi's approach. The first is that the conceptual framework adopted by the analysts determines both the questions asked, and the explanations given. Secondly, even if one does not accept Lowi's categorisation, he does provide a convincing case in support of the assumption that the policy area has a strong influence on the process or patterns of decision making, and hence support for the approach of this thesis. Thirdly, Lowi stresses that the major concern of the policy analysts is, or should be, the 'power' of the State.[19] In this the policy literature shares a major concern with the literature on French government and politics. Policy analysts however, unlike analysts of French politics, have spent some time attempting to define the meaning of the concept of power within the policy context. Before proceeding to the different ways of approaching policy, this debate must be discussed.

2.iv. **'Power'**

This is an immensely complex issue which cannot be resolved in the context of this literature review. The subject has been defined and redefined in numerous books, and it is unlikely that a definitive definition exists. However, it is important to analyse how the concept has been used in the policy literature and to indicate how it will be used in this thesis.

The literature on Public Policy provides an antidote to the vagueness of the French politics and Government literature on the question of power. The debate in the policy field was started by American academics as a result of a series of local studies attempting to assess the power structure and the policy output in States and towns.[20] This led to the development of a number of conflicting theories on the distribution of power within American society as well as differing analysis of the concept of power. Three identifiable models emerged from this debate: The pluralist model, most clearly expressed by Dahl, holds that power is evenly distributed between groups in society and that policy is usually the result of a compromise between groups. As a corollary of this it is argued that policy benefits are equally distributed throughout society and that policy is usually the result of a compromise between groups.[21] For the Millsian élitists, policy benefits are unequally distributed because power within society is concentrated in the hands of the few.[22] Neo-Marxist analysis goes further by identifying the minority interests involved as representing capital, and thus arguing that policy is designed to serve these interests, either directly or indirectly.[23]

However, it can be argued that the difference between the three models is the result of value judgements implicit in the definition given

to the concept of power.[24] In other words the three models, like those used by Allison to analyse the Cuban missile crisis, are not conflicting views of the same subject but are explanations of the same subject viewed from different angles. Lukes has identified the assumptions about power implicit in the three approaches. Firstly, the 'one dimensional view' of the pluralist school, which distinguishes between the capacity of 'A' to get 'B' to do something which he would not otherwise do, and the unsuccessful attempt of 'A' to get 'B' to do something he would not otherwise do. Here a distinction is being made between actual and potential power and the existence or absence of conflict. Dahl argues that power can only be attributed when its exercise is visible in concrete situations of conflict.[25]

A second approach developed in reaction to the first by Bachrach and Baratz is labelled the 'two dimensional view' by Lukes. Bachrach and Baratz accept most of Dahl's reasoning but argue:

> Power is also exercised when 'A' devotes his energies to creating or reinforcing social or political values and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to 'A'. To the extent that 'A' succeeeds in doing this, 'B' is prevented for all practical purposes from bringing to the fore any issues that might in their resolution be seriously detrimental to 'A's set of preferences.[26]

This introduces the important concept of the 'non-decision' and the power conferred through control of the policy agenda. Bachrach and Baratz go on to define policy as follows:

To the extent that a person or a group consciously or unconsciously

creates or reinforces barriers to the public airing of policy conflicts that person or group has power.[27]

Thus for Bachrach and Baratz power is exerted in situations where conflict is covert.

The 'three dimensional view' favoured by Lukes himself goes one step further. Lukes argues that the first two definitions identify power only in situations of overt or covert conflict over identifiable decisions, and ignore the 'system' itself which he argues creates bias which can be altered and mobilised in ways that are neither consciously chosen, nor the intended result of particular individual choices. The 'bias of the system' is sustained in turn by the socially structured, culturally patterned behaviours of groups/class and the practices of institutions. Thus power is not necessarily dependent on the existence of 'observable conflict'. Two types of power, 'manipulation' and 'authority', do not involve conflict. Thus 'A' may exert power over 'B' by getting him to do what he does not want, but 'A' also exerts power over 'B' by determining his wants without any evidence of conflict. In conclusion Lukes argues that 'the most effective and insiduous use of power' is to prevent such conflict arising in the first place.[28]

In terms of this view of 'power', policy is best explained within the wider context of the capitalist system. Thus for example for O'Connor, 'The fundamental effect of social security is to expand productivity, production and profits. Seen in this way social insurance is not primarily insurance for the workers, but a kind of insurance for capitalists and corporations'.[29] Alternatively Miliband sees the existence of social security systems as the necessary concession made to ensure the working classes' continued subservience.[30]

It should be noted that both these explanations contain statements about 'power' and 'policy impact'. In the former 'power' is apparently absolute and one sided; in the latter power is shared, even if unevenly. However, in neither is it clear whether the existence of power is deduced from the policy impact, or whether the existence of power explains the policy impact.

To return to the three definitions of power identified by Lukes, all three have in common the emphasis given to 'conflict' as the basis of the power relationship, but differ in how they identify 'conflict'. What is the basis of this difference? To use the abstract terminology of the theorist, 'power' is the process of 'A' doing something to 'B'. But, as interaction between individuals is permanent, any definition of power in these terms also involves a judgement on the significance of that reaction. The different definitions of power thus result from the individual analyst's evaluation of when interaction becomes significant. Lukes therefore concludes 'I would maintain that any view of power rests on some normatively specific conception of interests' and 'that power is one of those concepts that is eradicably value dependent'.[31]

If Lukes is correct, then no rigorously scientific definition of power is feasible. How then should we proceed? The object of this thesis is to explain policy and not to define power. However, as we have seen, explanations are a function of the initial assumptions. It is important therefore to consider each of these models as a possible basis for explaining policy, rather than attempting to fit the evidence into one of the frameworks. In the analysis of substantive policy issues that follows, I will consider all three approaches as a basis for explaining the actions (and in-action) of decision makers.

Although 'power' is clearly a crucial factor in explaining policy, the literature on comparative policy has shown that there are a number of other variables that explain differences in policy between countries. These range from indirect factors, like the environment, to the more concrete and traditional factors of institutions. Comparative policy analysis seeks to isolate and evaluate these different influences and determine which are general, and which country specific, and in so doing explain policy differences rather than simply identify them. Five major factors determining policy can be identified. These are: environment, the distribution of power, prevailing ideas, institutional frameworks, and the process of decision making. Each of these factors, which will be examined in turn, contributes to our understanding of aspects of policy making, and different authors have emphasised them in accordance with what they are trying to explain.

2.v. **Environment**

Under the heading 'environment' come a number of factors ranging from geographical situation, demography, industrialisation and urbanisation. The extent to which these explain policy depends on the aspects of policy under consideration and the nature of comparisons being made. Environment may provide an explanation of differences between broad aspects of policy in countries with very different environmental conditions. For example, the existence of a social security programme in one country and its absence in another might be logically explained by a high level of industrialisation in the former and a low level in the latter. Differences in housing policies in different countries may logically be explained in terms of different levels of urbanisation. The existence of family planning policies in one country and its absence in another may be attributed to levels of demography. This type of broad compar-

ative analysis does not however provide many insights on the policy making process as it predicts rather than explains policy and, what is more, predicts the predictable.

The 'environment' may also be an important explanatory factor of policy in comparisons involving similar countries with similar conditions and where their effect is far less evident. The main debate here is the relative influence of political and environmental influences on policy outputs.

Dye has argued that variations in policy outcomes between fifty American States are best explained in terms of environmental factors, and that political structure has little if any effect. His evidence in support of this theory was obtained by quantifying a number of policy outcomes ranging from education expenditure to indices of crime rates and the number of laws enacted. These were correlated with measures of political structure by quantifying factors ranging from party competition to interest group activity, as well as indices of environmental factors such as urbanisation, industrialisation, etc. He found that the most significant correlations were with environmental rather than political factors.[32]

There are a number of drawbacks to this approach. Firstly, like the conclusions drawn from comparisons between very different nations, there is an element of fools logic in this method. Given the similarity of procedures and policies in most of the States, it is reasonable to assume that (a) differences in policy output between them are likely to be minor, and (b) that the differences that do exist can be explained in terms of environmental factors. A second difficulty springs from

the problem of quantifying policy outputs. This is especially problematic in the case of cross national studies where different national budgeting systems make straightforward statistical measures of policy output invalid.

Finally this empirical approach to the subject leads to a neglect of the content of policy. An example of this can be seen in Philip Cuttright's index for measuring social welfare achievement. This index was compiled by summing the number of years of existence of retirement, health insurance, family, and accident insurance programmes in seventy six nations. This type of measure is of dubious value as it takes no account of the content, impact nor the variety of forms taken by these programmes.

In general however, the argument over the relative importance of environment or structure seems to depend on the level of analysis. If the aim is broad general theories about policy making in a number of countries, environmental factors may provide the most satisfactory explanation. If the analysis is more concerned with the details of policy making, the emphasis is likely to be on structural factors.

The most important drawback to this approach to policy is that although environmental factors may be useful as a means of identifying policy problems, they do not explain how the problems are perceived by the decision makers, nor how these decision makers choose between the possible policy responses to these problems - in other words the political process. Policy, in this approach, is isolated from politics and is seen in mechanistic terms, as resulting from certain inputs with the role of the policy maker ignored.[33]

Environmental factors are nevertheless important as a starting point in the analysis of policy as they both determine the nature of the problem, and the resources - intellectual, financial, and technological - available for their resolution. Thus the level of industrialisation is a source of a number of problems but does not explain the range of policies adopted to deal with them in different countries. For a fuller explanation other factors must also be included in the analysis.

2.vi. **Power**

This approach holds that policy is a function of the distribution of power and influence in society, the existence and conflict between groups representing different interests in society, and the means available to these groups to influence the policy makers. In the analysis of the concept of power above I have already noted the major definitional problems associated with this. What is relevant here is that the three different approaches lead to three different explanations of policy.

From the pluralist approach the central concern is identifying the different groups involved in the decision making process, analysing the bargaining process, and presenting the compromises that result from it. This approach may be criticised as distorting reality by only analysing certain 'critical' conditions and for ignoring, as already mentioned, the question of non-decisions. Another criticism of this approach questions the extent to which it is descriptive or prescriptive. The policy process described by Dahl assumes the existence of consensus on the rules of the game and the political structure and only a moderate level of conflict. All policy problems are seen as soluble by the analyst and the groups involved all accept the need for compromise. This may be true for some policies some of the time, but not for all policies all

For the élitist, policy benefits the few as a result of the uneven distribution of power. For the Millsian élitist and Marxist, the central concern is that of identifying the élites involved in the policy making process, and in the latter case their class, and shows how the benefits of the outputs of the process are unequally distributed throughout society, or benefit principally one part of society at the expense of another. The problem of this approach is that it provides a very broad explanation of policy. A capitalist system of production exists in most advanced industrial nations. All democracies are imperfect in the Millsian sense, but nevertheless there is a great variety in the forms of government, and the form and nature of benefits provided by these governments. The function of the policy analyst is to explain these differences, which are far from all being determined by impersonal economic or social forces. The Marxist approach might also be criticised in the same terms as the pluralist approach in that it confuses theory with reality.

A final criticism which applies to all the three different uses of the concept of power is that they all concentrate on this concept to the exclusion of all other factors, and thus assume that the possession of power will lead automatically to certain desired ends, without actually identifying what these ends are or analysing how they are achieved.

2.vii. **Ideas**

J.M. Keynes is reported to have observed that:

> The ideas of economists and political philosophers are more powerful than is commonly understood. Indeed the world is ruled by little else. Practical men, who believe themselves to be exempt from any intellectual influences, are usually the slaves of some defunct

economist.[34]

Keynes may no longer be that defunct economist, but his observations still hold true. Ideas on the role of the state, the nature of man, the rights and obligations of the citizen, have a major influence on what issues reach the policy agenda, the policy responses that are considered, the way policy choices are taken, and the way in which policy is implemented.

Ideas may refer to the political system or to policy. In the case of the political system they involve attitudes towards how the decision making process should work. Writers like Almond and Verba have made a good case for the concept of 'political culture' as the basis for explaining different forms of political system and political activity.[35] Thus in Western Europe and the USA ideas about the political system help identify accepted 'rules of the game', the legitimate methods for influencing decision makers, whether decisions are taken on the basis of a simple or absolute majority, or unanimously, and the extent of participation in the decision making process of non-government actors. The 'political culture' of a country may explain the structure of the system and the style of decision making, but an additional step is required to link this with policy outcomes. The problem is estimating the independent effect of different styles of policy making on policy outputs and outcomes. A comparison of social policy making in Sweden and Britain by Heclo succeeds to a certain extent. He attempts to show not just how the process of policy making differs from country to country but also the significance for policy outputs of the differences.[36]

The problem with this type of approach to policy is twofold. Firstly, it tends to explain very broad 'systems' differences between countries

which may not be very useful in understanding specific policies. Secondly, the influence of ideas on the political structure has been a long and continual process and as a result it is difficult to determine their exact importance. Might not the institutions have an equally important influence on the dominant ideas about the political system?

Like 'ideas' on the political system, 'ideas' on 'Policy' are both amorphous and difficult to assess. They concern attitudes about what governments should do. This may involve the scope of government activity, whether decision making is centralised or whether it is delegated to local units of government, as well as the goals of government. For example the relatively limited role of the State in the USA is most satisfactorily explained according to Anthony King by the fact that, 'Americans, more than other people, want it to play a limited role'.[37]

By the same token the existence of the Welfare State in Britain may be explained, not by the changed industrial structure, but by the existence of beliefs about the responsibility of the state towards its citizens, or along the left-right dimension in terms of the dominant ideology at the time.

It is clear that 'ideas' have an influence on the way decisions are reached within particular societies, but that this influence is closely interlinked with other factors, and that separating them is a highly complicated task. 'Ideas', in the general sense, only help to explain broad shifts in direction over a long period of time, and as such their influence is indirect and often only observable after the event. Thus they are of limited use in explaining the process of policy making. The influence of 'ideas' on policy makers however is more immediate,

and may play a more important role. In the case of France, it is possible to argue that the dominance of the administrative philosophy of the 'intérêt général' has an observable effect on both the way in which policy is made, and the content of policy, or to chart the influence of planning rationality and its effects on policy output. In another context ideas produced in universities may have a strong influence on whether an issue gets on the policy agenda or not. According to Banting academic research into poverty, made an important contribution to the welfare and housing policies developed during the sixties in the UK.[38]

While 'ideas' may influence the policy perceptions of decision makers, they do not satisfactorily explain the process of choice between available solutions. They are thus only a partial explanation which must be considered along with others. It must also be recognised that within any existing society a wide range of ideas exist and, given that they cannot, unlike votes, be counted, any explanation of policy in terms of ideas must explain their source, the reasons for their success, and their selection by policy makers as valid expressions of public will, or as worthwhile policy goals.

2.viii. **Institutions**

The Institutions of a country have traditionally been the focus of attention of political scientists. Political systems have been categorised as one, two or multi-party, governments as Presidential or parliamentary, nations as unitary or federal, bureaucracies as centralised or decentralised. The aim of the policy analyst is to compare institutional differences and assess the importance of these for the way policy is made, and policy itself. Thus Ashford asks:

Do States have characteristic ways of conducting their business?...

> Is the most interesting thing about the modern State that it encounters similar conflicts, and must make similar choices, or is it that it has done these things in such a variety of ways?[39]

His answer to this question is that the constitution and formal institutions of a country are vitally important to explaining the complexities of the making and executing of policies. Ashford provides a demonstration of his theories in his comparison of local government reform in Britain and France. He argues that reform was rapid, authoritative and centralised in Britain, and as a result not entirely successful. In France by contrast reform was gradual, involved a large number of political actors and was consequently more successful. His explanation for the different policies and the different approach adopted in each country goes back to the introduction of democracy in the two countries. In Britain, he points out, this was a relatively painless exercise involving a gradual extension of parliamentary democracy. In France the introduction of democracy was a violent affair, dependent on the support of local political actors for its survival. As a result in Britain parliament remained strong, and local political actors never became significant power brokers. In France, just the reverse. Ashford thus supplies an analysis of both the content and process of policy making.[40]

The absence of a welfare state in the USA is usually explained in terms of the dominance of certain 'ideas' about the right and proper role of the State, and the importance of the individual. Another, contrasting approach to this issue argues that it is certain institutional features that are more relevant to understanding why such a policy innovation has never been successfully adopted. The relevant institutional features are federalism, the separation of powers, the supreme court, the style of politics in Congress and the party system. In general

the USA represents a far more fragmented polity, and as a result the political elites in favour of welfare policies are less able to overcome the popular and interest group opposition to raising the necessary resources for such programmes.[41]

In the case of France the institutions are clearly an important factor. As noted earlier much of the literature has concentrated on describing Presidential power in France. However, what has not been established, although the form of political activity has clearly changed, is the connection between this and policy outputs. Put in other words, policy outputs might have changed despite the institutions, not because of them.

Both the examples quoted above involve comparisons between very different cases. Very different institutions are thus a convincing explanation for different policy outputs, but given the nature of the comparison it seems reasonable to assume similar differences between the other factors influencing policy. In contrast, within Western Europe it is possible to identify countries with different institutional frameworks, but very similar policy outputs. For example, Federal Germany has a National Health Insurance system similar to that of centralised France. Ashford has established a good case for assuming that institutions do have some independent effect, but their influence is in turn linked and intertwined with other factors.

2.ix. **Process**

The 'process' approach is the key to understanding policy making, as it is through the process of policy making that the various factors outlined above are translated into policy. There is no direct link between

factors such as the environment, the dominant ideas in society, the distribution of power, and the particular institutions of a country and policy. These are all abstract concepts which can, and have been, studied as such, but policy is dynamic and in order to make concrete the analysis of policy it is necessary to show how these factors influence the actors involved in the process of making policy and hence explain, rather than assume, their importance for policy outcomes.

The 'process approach' concentrates primarily on the actors directly involved in policy making, and has tended to see policy as an intellectual activity. As noted earlier, the literature can be roughly divided between those analysts prescribing how policies should be made, and those attempting to understand the realities of how policies are made. However, it is often difficult to place authors confidently in one or other of the above categories. Heclo has compared the debate over whether policy analysts can and should attempt to be policy relevant to the dilemma of the impotent man trying to decide whether to enter a brothel. The result is irrelevant. Nevertheless, those authors who have sought to be 'policy relevant' do make a valuable contribution to the literature in the sense of developing new theoretical models as starting points for further research.

Contributions to this literature have come from a wide field, including that of organisation theory. This was applied first to the study of the firm but the same approach was later adapted by Simon, alone or in collaboration with March, in a series of articles and books.[42] Simon emphasises that policy or decision making is an intellectual process. Thus he argues 'that organisation members are decision makers and problem solvers, and that perception and thought processes are central

to the explanation of behaviour'.[43] According to Simon, organisations, and thus bureacracies, are also goal orientated and that, in seeking to achieve these goals, 'we must not lose sight of the fact that, however far organisations may depart from the traditional description of neutral instruments of governmental policy, nevertheless most behaviour in organisations is intendedly rational behaviour'.[44]

Given these assumptions about the nature of organisations and the role of decision makers within them, Simon proposes a model of the ideal process of decision making. This suggests that in any situation an administrator should identify all possible solutions open to him, should assess the expected consequences of each course of action, evaluate the benefits and costs in terms of his goals of each of them, and finally decide on that option which presents the least costs and is closest to meeting his objectives. However, having established this theoretical model of the process, Simon admits that it reality the rationality of the decision maker is limited in two important ways. In the first place rationality is limited by time, and the pressure of events. As a result, decision makers in reality will accept the first satisfactory solution to a problem rather than seeking the optimum solution. Simon terms this the 'satisficing' solution.[45]

The second limitation on rationality is more fundamental. 'Perfect rationality' is unobtainable in the real world as the limits of man's knowledge make it impossible for all options to be considered. It is also impossible for the decision maker to foretell future consequences totally accurately. Finally, in many cases it is difficult to quantify the costs or benefits of the predicted results of decisions. Thus in all cases, it is argued, the rationality of decision making is far from perfect.

However, as Simon's aim is to recommend ways of improving rationality of the decision making process, he suggests ways of limiting the options from which decision makers must choose, and the 'consequences' that need be considered, as well as a standard formula for calculating costs and benefits. Thus while the decision itself may be subject to limited rationality, the process of decision making is absolutely rational.

This short résumé of the theories of Simon illustrates the subtle mix of descriptive and prescriptive approaches. On occasion it is difficult to separate the analysis of how organisations work from the recommendations for how the working of organisations might be improved. In fact it could be argued that Simon has proved Heclo wrong in that his ideas have strongly influenced modern corporate and bureaucratic thinking. This does not necessarily mean that his analysis of the decision making process is accurate. Self argues that 'Simon's description of an administrator is really that of a planner'[46], whose function is to offer various options and assessments of their likely effects to the decision maker. The planner is free from the constraints of day-to-day administration and thus has the time to analyse all aspects of policy options. But planning is only one small and very specialised aspect of policy making.

The most important limitation of this approach is that Simon assumes the existence of an objective rationality. However, as 'rationality' may refer to both the 'means' by which objectives are achieved, as well as to the objectives themselves, and while 'means' may be evaluated purely in terms of their efficiency, the objectives of an organisation are in contrast the product of different rationalities. It would be wrong to assume therefore the existence of a consensus on these objectives.

As means are indissociable from objectives, it is unlikely that a consensus on their rationality will exist either.

In searching to devise and propose ways in which the policy making process might be improved, March and Simon tend to neglect the political aspects of this process. Policy is also the result of choices made between competing interests and groups in society. A different approach correcting this imbalance, but one that still concentrates on the small group of actors closely involved in the process, is adopted by Lindblom.[47] Lindblom's theories of incrementalism have been described alternatively as being in complete opposition to Simon's conceptualisation of decision making[48] or, by Dunsire, as a complementary approach.[49] Amitai Etzioni argues that the two approaches are complementary and should be used together; Lindblom's incrementalist approach to the preparation of decisions, and incrementalism again for the implementation stage of the process. Etzioni describes this as the 'mixed scanning' approach.[50]

Like the theories of Simon, it is difficult to tell where Lindblom leaves off describing how policies are made and starts prescribing how they should be made. Like March and Simon he recognises the limits imposed by the real world on rationality, but differs in the greater emphasis he places on the difficulty of identifying policy goals which are the subject of political conflict. However, he argues that this is <u>not</u> the way decisions are made. According to Lindblom, only solutions marginally different to the status quo are selected and evaluated by decision makers. In the real world policy means are not determined by policy objectives, but rather policy objectives are determined by available means. This means that policy objectives are constantly changing rather than being fixed, and that policy is a continuous process, in which problems tend

to be repeatedly attacked, rather than solved. According to Lindblom the main function of policy makers is as problem solvers rather than as promoters of ambitious goals. Linblom calls this type of policy making marginal incrementalism. In this situation the most reliable indicator of policy at any given time 'T' is unlikely to be any of the factors mentioned earlier, but policy at 'T-1'.[51]

Lindblom argues that not only is this the way decisions are made in the real world, but also that it is the best way. In his view the fact that policy only changes marginally ensures against any section of interests within society being permanently disadvantaged before they have time to organise a response to that policy, and that the step by step approach to policy making allows decision makers to continually reassess and update policy to account for new demands and unexpected consequences of policy.[52]

This description of the decision making process is an improvement on the utopian model proposed by Simon, but nevertheless presents a number of problems. Lindblom clearly assumes the existence of a democratic pluralist system in which partisan interests are well represented. However, even when applied to the American system it is not completely satisfactory. For example Heidenheimer, Heclo and Adams have described what they call 'a peculiarly American dynamic in policy making'. This involves in normal times slow and gradual policy adaptions involving a long and complicated process of consensus building which corresponds well to Lindblom's 'incrementalist' model, but they argue that the very incrementalist nature of change is also conducive to occasional extreme policy swings. If Lindblom's system is to be more than a description of routine administration, they argue, it must explain

the real observable increases in public expenditure and the dramatic changes in public policy that occur from time to time.[53]

Another problem with Lindblom's analysis is the question of when an incremental decision is no longer an incremental decision. The significance of this issue is highlighted by the two case studies set out in chapters 6 and 8. If all policies do not fall into Lindblom's 'incremental' category, then it is important to identify the different characteristics which distinguish 'incremental' type policies from policies which involve more drastic forms of change.

Another approach to policy analysis unashamedly seeks to improve the process of decision making. The basic assumption of this approach is that if we were more scientific in our study of policy we would eventually reach a stage where we knew what policies and what methods were best suited for achieving given policy objectives. This approach stems from a view of policy as primarily a technical problem involving the bureaucracy and its methods. Y. Dror, one of the main exponents of this approach, argues that 'the main concern of the policy sciences is the understanding and improvement of societal directions; the main test of policy sciences is better policy making which produces better policies'. These in turn are defined as policies which provide 'increased achievement of goals that are preferred after careful consideration'.[54]

The main weakness of Dror's approach is that he takes 'policy' as given, rather than analysing how policy objectives are selected. As a result he concentrates on the implementation of policy, and the significance of political actors and choice is underestimated. This approach tends to assume that given better information on the policy

problem, and knowledge of the process of policy making, there will be one universally accepted rational solution. However, policy makers see problems and their solutions from a variety of perspectives, thus conflict over the choice of options, and implementation of policies is not simply the result of bureaucratic bloody mindedness or incompetence, but also due to differing values and interests.

Another example of this approach is Bardach's 'The Implementation Game, or What Happens after a Bill Becomes Law'. In this rather pessimistic view of implementation of mental health reform in the USA, Bardach conceptualises the process in terms of a series of games played out at different 'decision points' in the legislature, or the administration, and over various issues such as funding, and the time scheduling of implementation. His conclusions are pessimistic in that he argues that a large number of games take place, many of which are bound to be lost, and that with each game lost, the original objectives of the policy are displaced. Only exceptionally he argues are objectives achieved, and this as a result of 'fixing' the game. In the case of the Mental Health Reform Bill described by Bardach, this involved a 'deux-ex-machina' in the form of a retiring senior congressman with powerful allies in government, anxious to leave behind him some kind of memorial to his political career. This key political actor followed the Bill through its various stages, fixing games where necessary to ensure that the final result was right. However, Bardach argues, this was the exception that proved the rule.[55]

What Bardach brings out extremely clearly is the complexity and difficulty of policy making and implementation. Thus he writes:

It is hard enough to design public policies and programmes that look

good on paper. It is harder still to formulate them in words and slogans that resonate pleasingly in the ears of political leaders and the constituencies to which they are responsive. And it is excruciatingly hard to implement them in a way that pleases anyone at all, including the supposed beneficiaries or clients.[56]

This observation has a wider application than the limited case observed by Bardach, or even policy making in the United States. It has a general validity for policy making in western industrialised nations, and suggests the need for a new, and more sympathetic evaluation of the performance of the French administrative system.

2.x. **Conclusion**

The Policy Analysis literature outlined above clearly shows that explaining policy, as opposed to describing policy is an extremely complex task. This task cannot be accomplished without a clear conception of what policy is. Policy, in the context of this thesis is in the simplest of terms 'what governments do', but as we have argued this must include an evaluation of both policy making and policy implementation, the implicit and explicit objectives of policy makers, and the eventual effect of policy on the target population.

Depending on what aspects of policy the analyst seeks to explain, a number of factors influencing policy outputs may be identified. The environment, dominant values, the distribution of power within society, the institutions of a country are all factors that clearly have some influence on policy making, but no one of these provides a completely satisfactory explanation. The advantage of the 'process' approach to policy is that all these factors are taken into account, and that politics,

or the process of choice between conflicting interests, is given its rightful place within the analysis.

Whatever the approach to policy, it is clear that the concept is a complex one. This complexity is further increased by the introduction of another variable - the effect of policy on policy. In other words the very nature of the policy being analysed may be an important factor in explaining, as an independent variable, the policy making process itself. This poses an important question. Do political processes vary in accordance with the issues or stakes in the game? It would seem reasonable to assume that in different policy areas, different actors are involved, different values and attitudes at play within a different institutional context. And that as a result the policy making process differs from case to case. Some support for this hypothesis exists within the literature on Health policy, the subject of the next chapter.

Chapter Three

HEALTH POLICY

3.i. Introduction

In the preceding chapter I argue that health policy analysis should logically be considered a constituent part of the policy analysis literature. As such, the reasons for studying health policy and the approaches adopted by analysts are very similar. The rising costs of health and the increasing salience of health policy as an issue have led to a series of studies during the seventies of European health systems by American academics, many with the explicit or implicit intent of providing support for the proponents of a national health insurance system in the US.[1] In countries where a national health insurance system exists, the escalating cost of health care and the apparent inability of governments to control these costs, has led to a growing demand for information on the nature of different health systems.[2] However, health policy analysis may also take the form of social criticism. As national health systems have become comprehensive, researchers have begun to question the extent to which these systems have succeeded in meeting their initial objective of providing equality in health care.[3] Finally, health policy analysis has also been used as a way of approaching political systems.[4]

As in the general policy literature, different emphasis has been given to a variety of factors as explanatory variables of health policy. This does not necessarily indicate that these explanations are contradictory, but rather that different phenomena are being explained. One of the objectives of this thesis is to identify those factors which are specific to health policy, and those factors of health policy making which seem

to be primarily a function of the political and institutional processes of a given country.

3.ii. Why Health Policy?

The short answer is that health policy is a matter of life or death. The impact of health policy may not be felt by all the inhabitants of a country all of the time, but it is safe to predict that it will be crucially important to all at least once in their life. Health policy is also about the quality of everyday life, and is a policy area in which decisions affect the total population and have considerable bearing on a commodity that is increasingly valued by the individual. Yet, paradoxically, health policy is far from being a salient political issue.

It is now largely accepted in Western Europe that the provision of health care is one of the responsibilities of the State. Up until recently the primary objective of health policies has been to ensure equal access to health care.[5] This objective has now largely been achieved in Western Europe, although this of course depends on one's definition of equality. However, the result of this success has been rapidly escalating health costs which have become all the more apparent as the economic crisis has deepened. What makes the situation even more worrying in the eyes of policy makers is that increased expenditure on health has not led in the short term to any significant improvements in the general accepted indicators which measure the health status of a nation. Attempts at controlling the increase of health costs take place in a variety of institutional contexts, but have met with limited success. The United Kingdom seems to be the exception, but that success may have been bought at the expense of capital spending, and an informal form of rationing based on the queue.[6] Thus in the field of health policy, there

is a clearly identified 'problem' which policy makers are attempting to deal with by way of a number of different policies. This policy area therefore provides an excellent opportunity to assess the relative importance of the political process or policy characteristics on policy making within a given country.

3.iii. **What is Health Policy?**

Health policy is a complex and difficult concept to define. A simple definition is that health policy is action aimed at protecting and promoting the health of a given population. This definition appears to be self-evident, but a Marxist might argue that the main objective of health policy is, on the contrary, to ensure the maintenance of an efficient workforce, and to repair the ills resulting from a certain style of production, with the secondary aim of serving capital accumulation in certain sectors of the economy.[7] Other possible definitions of health policy abound. A more sophisticated approach to the concept is to define health policy in terms of the groups involved in the provision of health care, or in terms of the highly specialised and technical product being provided. The above takes health policy to be what governments do in this field, and does not assume that health policy is necessarily action taken by government designed to improve the 'health' of the nation.

In contrast, the World Health Organisation defines health as the 'total mental, physical and social wellbeing of the individual'.[8] If one accepts the arguments of Ivan Illich, who claims that most health policies are in fact detrimental to the 'mental, physical and social wellbeing of the individual'[9], then very few countries can claim to policies promoting health. The term 'health' is thus slightly misleading, most of the health policies followed in industrial societies are in fact financial policies,

and health policy is best conceived in incrementalist terms as the actions of government relating to the existing health system of a country.

In this light health policy can be seen to have two aspects. In a wide sense it may be defined as the actions taken by government relating to an existing health 'system' made up of institutions where health care is provided, the groups involved in the provision of health care, and arrangements for financing that care. In a narrower sense health policy may be defined in terms of specific policy options in response to immediate problems. On that basis it seems reasonable to assume the existence of at least two possible explanations of policy. In the first case any explanation of policy would tend to stress the history of the health system, and the importance of broad political and social forces, and hence suggest the particularity of health. In the latter case the emphasis is likely to be on more micro aspects of the political process and hence stress the uniqueness of a particular political system. Both approaches are explored in chapter four, and the two case studies which follow.

3.iv. **'Lessons from abroad'**

A large part of the comparative health policy literature is a product of the political debate that took place in the United States during the seventies around the issue of national health insurance. A good example of this is the work of Glaser. He argues that 'If the United States is the world's last developed country to enact national health insurance, the subject should not be so mysterious and confusing. America need only look at the many other countries that have long had it in order to learn whether any of Washington's anxieties are vindicated'.[10] Glaser however is as much a policy propagandist as a policy analyst. Setting out the arguments for a national health insurance system, he attempts

first to demystify the concept by explaining that it is 'simply a way of paying doctors, hospitals, and other suppliers of health care on a large scale with a number of advantages'.[11] The advantages he highlights are that the system allows the consumer to calculate exactly how much his treatment will cost, and how much of this he will have to pay out of his own pocket. This has the effect of making 'access to care more equal', as the poor patient is covered by insurance in the same way as the rich, and it incorporates incentives for doctors to move from areas with a high medical density to less well provided for areas. In addition he argues that these advantages are achieved without sacrificing the independence of the medical profession, or changing the organisation of the hospital system. The only sacrifice he identifies is that doctors must agree to negotiate and abide by a standard fee schedule. Far from reducing doctors' income he argues that this is likely to increase as fees are levelled upwards, and bad debts eliminated. Finally he claims that the introduction of national health insurance would not necessarily feed inflation in health costs. This could be avoided by health insurance organisations and the government acting in concert to resist pressures for higher fees from the medical profession.[12]

In this article Glaser assumes that policies that have been effective in Western Europe can be exported to the US, and perhaps intentionally minimises the many real problems faced by national health insurance systems. In a more considered work, however, Glaser concedes that 'while no country is unique, neither is it an exact duplicate of another. Institutions and cultural traits resemble each other in various ways from place to place, but the total mixture is distinctive' and that as a result ready built policy solutions are not exportable.[13] However, he goes on to argue, calling on the policy process theories of Simon and Lindlom,

that the policy experience of other countries may help the decision maker identify policy options and estimate the likely result of these, as well as learning from others' mistakes and successes.

It is clear that Glaser, while recognising the importance of cultural, ideological and institutional factors for policy, assumes the existence of an important residual determined essentially by the nature of the policy involved. This residual is conceived not in terms of policy, but as techniques or methods of management, devoid of political connotations. Thus in his analysis of different health systems, his aim is to identify 'the various devices that work well, and other techniques that are troublesome'.[14]

In the area of health policy Glazer identifies the 'device' whereby the medical profession are remunerated, as of crucial importance. He argues that the three different systems of paying doctors - fee for service, capitation or salary - have a significant impact on the nature of the health care provided, as well as the form taken by negotiations between the health insurance organisations and the medical profession. This argument is supported by evidence from case studies on systems of financing health care in Western Europe.[15]

If one of the reasons for the emergence of policy literature was the neglect by analysts of the 'output' of government, Glaser's work is perhaps an example of the opposite extreme. A major weakness in Glaser's work stems from his concern to be policy relevant. The emphasis in Glaser's analysis is on micro aspects of policy and the the extent to which the 'techniques' he identifies could be applied in the US context. As a result he does not fully explain how the policies followed in the

countries he has selected came to be, and how the micro aspects of policy fit in, but takes them as given. In addition he sees these policies through the conceptual lens of the American policy making process, giving only very summary consideration to the particular political and institutional contexts of each country. This can produce some rather sweeping and unhelpful generalisations about the political systems and the political processes in the countries concerned. Thus Glaser classifies France as a 'centralised unitary' nation, failing to remark that one of the most interesting aspects of health policy in France is the apparent decentralised nature of the health system. Similarly, on the policy making process, he asserts that 'large impasses are often resolved by conversations among the leaders (of the parties involved in health insurance negotiations) assisted by Paris' greatest contribution to the building of consensus, haute cuisine'.[16] Another example of the approach which seeks to draw out policy lessons for the US from the experience of other countries is the work of Roemer.

The work of Glaser and Roemer illustrates the major methodological problems faced by policy analysts. The source of this problem lies in the basic contradiction between the policy analyst's objective of developing broad theories explaining 'universal' issues, and the need, if these 'universal' issues are to be understood and valid theories developed, for detailed research into the minutae of policy and policy making. Roemer has attempted to provide a broader analysis of health policy making, analysing a number of aspects of health policy in a variety of different political systems.[17] He can be criticised on the grounds that his theories are too general and don't help us understand why policy 'A', instead of policy 'B', was adopted in a specific context. By adopting Glaser's approach this could be explained in detail, but

this time the explanation would be open to the criticism that it ignores the broader social and political context of the problem.

An approach that seeks to combine an awareness of the socio-political context at the same time as adopting a 'micro' policy analysis can be seen in the work of the 'Centre de Recherche en Gestion' (CRG). Their interest is in the way micro-aspects of policy making are affected by both the socio-political and the policy context. Unlike March and Simon, the work of the CRG is founded on the conviction that organisations are not governed by the same immutable rules whatever the country, but that their political and social context is essential.[18]

The concept of 'policy techniques' is crucial to this approach. 'Policy techniques' ('instrumentation' is the French term used) are defined as the terms in which a situation is traditionally described and measured and the tool used by policy makers to influence this reality. The theory behind this concept is that 'l'instrumentation d'une politique telle que nous venons de la définir acquiert progressivement une autonomie et une logique propre, au point de déterminer parfois les effets de la politique elle-même'.[19]

This is the basis on which Jean de Kervasdoué claims that 'it is impossible to say that there is one method of producing health care... there is what can be qualified as a culturally determined production function'.[20] de Kervasdoué justifies this claim by arguing that in the health field there is no clear link between means and ends. However, because all organisations by their nature demand quantifiable information, the goals of health policy have been displaced by a measurable concept like morbidity, and the means measured in terms of another quantifiable

element, or medical 'acts'. This ensures that the techniques of health policy can be formalised, and their efficacity can now be measured. The main purpose of this is to give policy makers the means to control the organisation of health provision.[21]

From this conceptual viewpoint de Kervasdoué suggests the following. Firstly that the systems for the provision of health care have 'no reason to be the same from country to country, especially as policies in areas other than the medical (social laws, powers of local government...) have direct consequences for health expenditure and for the organisation and distribution of medical care'.[22] Secondly that the techniques whereby policy is measured gain an importance far exceeding their primary function.[23] An example of this given by Gérard de Pourvouville is the system of the nomenclature, a list classifying the activities of doctors and attributing to each a value on the basis of which fees are set, and refunded by the insurance funds. According to de Pourvourville, this 'outil de mesure' has a far more important function than that for which it was designed. Far from being a simple measure of medical activity it is used by policy makers to discourage certain medical activities.[24]

This form of analysis provides much useful information on the micro-aspects of policy making, and the workings of the particular aspects of the French health system like the nomenclature, but as with Glaser and Roemer, the authors set themselves, or are set, limited objectives. In the case of the former the objective is to learn from abroad, and as a result the net is cast wide. The CRG in contrast is in competition with other research groups for contracts from public or semi-public bodies for research into specific and limited policy problems. To continue

the fishing metaphor their aim is to place the fly in the most promising part of the stream, and as accurately as possible. As a result the conclusions of the CRG researchers are of limited value to general theory. Although their initial assumption is that in each country specific institutional and cultural characteristics determine policy they do not show this to be the case for the policy process as a whole, but rather assume this to be the case on the basis of specific examples. Thus micro and macro analyses of policy both make valuable contributions to our understanding of policy, but each on its own provides only an imbalanced and partial explanation of policy.

A full explanation of policy must therefore take account of broad characteristics of the political context of decision making, the particular characteristics of the health policy arena, as well as the details of the administrative arrangements for the provision and financing of the health system, and the nationally particular characteristics of health care in specific countries.

3.v. **The Power of the Medical Profession: Politics or Policy.**

The issue of the power of the medical profession illustrates the broader relevance of policy analysis. In the field of health policy the importance of the role of the medical profession and the nature and extent of their power have long been a focus of attention. The importance of interest groups whose power and legitimacy is derived from the possession of specialised knowledge, or the control of sophisticated technology, has become increasingly relevant in industrial societies. The medical profession is the oldest and most highly esteemed of this type of interest group.

The major issue in this literature is the debate over whether the power of the medical profession is a function of the special nature of medical activity or whether, on the contrary, medical power is enhanced or limited by the particular institutional arrangements of a given country. A comparative approach to this issue is one way to attempt to answer this question, for if it is the nature of medical activity that determines the power of the profession then one would expect doctors to be equally influential across nations. If on the other hand 'medical power' is a function of institutional arrangements, then one would expect a considerable degree of variation from country to country.[25] Marmor and Thomas have argued the latter case. In their view the economic and political resources controlled by the medical profession are a product of the nature of the services they provide, and far outweigh any institutional differences that might exist between nations. Thus they state:

> As producers of a crucial service in industrial countries, and a service for which government can seldom provide short run substitutions, physicians have overwhelming political resources to influence decisions regarding payment methods quite apart from the form of bargaining their organisations employ.[26]

It is worth noting however that this statement refers only to one aspect of policy. If the power of the medical profession is great, but is limited to one small area of health policy, then it might be more reasonable to conclude that overall their power is limited.

A contrasting analysis can be found in Eckstein's now classic study of the British Medical Association (BMA) and the National Health Service (NHS).[27] Eckstein's chief concern is with pressure groups in general and the form that their activities take. He argues that these are determined by the characteristics of the political system; for instance

whether government is Presidential or by cabinet, the loci of decision making, and the generally accepted ideas about the role of government and interest groups. This leads him to conclude that it is the specific political and social factors of the English political system that explain the influence of the BMA on the NHS.

However, according to Eckstein, one of the factors explaining the influence of the BMA was the absence of public interest in, or rather the existence of a consensus on, a highly technical policy field. This suggests that the policy characteristics of health go some way to explaining the influence of the BMA. As a result of this consensus, Eckstein argues that policy in the health arena is made by a small group of actors from the Ministry of Health, the Treasury, and the élite of the medical profession, in secret negotiations. However, Eckstein sees nothing sinister or undemocratic in this but suggests rather that 'It is the result of a high degree of consensus on fundamental policy, and the shift of disputes (partly because of fundamental agreement, partly for other reasons) to technical issues which most people do not and need not understand'.[28]

If one accepts this argument that the most significant form of power is exerted where no apparent conflict exists, a different interpretation might be put on the negotiations between the BMA and the government of the day described by Eckstein. The importance of the influence of 'ideas' on policy makers and policy analysts is also evident here. Eckstein was writing before the publication of books like Illich's which question the technological legitimacy of the medical profession, and before the development of what might be called the health movement which has manifested itself in the form of fashions like health foods, jogging, and

alternative medicine. Technology is no longer a recipe for consensus and is increasingly being challenged by consumers. Issues that seem purely technical have become topical as a result of changing attitudes. Likewise apparent consensus has been transformed into overt or covert conflict.

Whether the influence of the medical profession stems from the nature of the service they provide, or social and political factors, is far from clear. D. Stone attempts to provide some answers by analysing the nature of medical power more closely. She does this by identifying the kind of decisions and resources physicians actually control.[29] As a result Stone argues for the need for distinguishing between the collective and individual dimensions of medical power. The most common approach to this subject deals primarily with the collective power of the medical profession. As a result, according to Stone, a fundamental point is missed. Although medical power is exerted from outside government through medical interest groups, 'the profession itself is also a quasi-government with various kinds of de jure and de facto authority to govern the behaviour of individual physicians, medical schools, and hospitals'.[30] In addition governments frequently delegate a large degree of responsibility to professional bodies not just for their own internal organisation, but also for the making and implementation of health policy.

Thirdly Stone points out that members of the medical profession also exert power individually, as doctors' decisions determine the volume and nature of health services provided to the consumer, and hence the cost of the nation's health care. Where a national health insurance scheme exists, the doctor effectively decides what the consumer will consume and what the payer will pay. Finally the individual doctor is also the 'gatekeeper' to a number of non-medical cash or other benefits.

Of the two forms taken by medical power, collective power seems to be the most important for policy analysis, as the influence here is purposeful, rather than the result of the uncoordinated and independent wills of all doctors. As a result of evidence drawn from her study of the German medical profession, Stone concludes that the collective power of the profession is largely a function of institutional arrangements. The medical profession in Germany, she argues, is closely integrated with the State not because it is the medical profession but because this is the norm for all professions. Self-regulation by the profession is justified not in terms of the particular nature of the service being provided, but in terms of a conception of society as an organic whole made up of self-regulating economic groups coordinated by the State. In Germany a national health insurance system was established early and all doctors were obliged to join a single medical union. As Stone describes, 'the power of an expert group is consolidated by deliberate legal arrangements, but then confronted by a counterveiling power that is also the creation of political arrangements'.[31] This arrangement is not peculiar to health, but is part of the German political culture.

Stone concludes that while aspects of medical power may be explained in terms of the nature of the service provided, the collective power of doctors in Germany 'can be accounted for by the characteristics of the political system and by political decisions, rather than by the technical nature of medical care or by ideological beliefs and values about health care'.[32]

Although Stone's analysis is based on evidence from the German system it raises a number of questions which profitably could be addressed to the issue of the role of the medical profession in France. The role

of the medical profession, both collectively and individually, is clearly important in France. France, like Germany, has a National Health Insurance system, but this is far less well established. French political culture however is very different from its German counterpart, as is the institutional context. However, the position of the medical profession in France appears to be paradoxical: at one and the same time it seems to exert considerable influence on the government and to be totally powerless. Like their German counterparts the profession is extensively consulted by government, yet at the same time it feels the need to organise mass street demonstrations to protest against government policy. One possible explanation for this is that unlike the situation in Germany there is no clear distribution of power or allocation of responsibility in the French health system. In chapter six, which deals with the process of negotiations between government and the medical profession over tariffs called the 'Convention Nationale', I will attempt to determine the extent and nature of medical 'power' and the way in which this influence is exerted. From the evidence of this case study I will also try to draw some conclusions as to the extent to which this influence, or absence of influence, is explained by political variables or by the specific characteristics of the policy area.

3.vi. 'Professional Monopolists and Corporate Rationalisers'

While Eckstein, Stone, Marmor and Thomas concentrate on the interaction of the medical profession with policy makers, a broader perspective can be found in the work of Navarro and Eckstein, but one which, in common with the above, nevertheless has an emphasis on the distribution of power in the health arena. The key to Navarro's explanation of health policy is his contention that health policy cannot be understood in isolation from society as a whole, and that the most satisfactory model

of society is the Marxist one. Thus Navarro argues that 'in order to understand the behaviour of actors in the health sector, we have to understand their positions within the overall economic and political scheme of our societies, i.e. their class position.'[33]

Navarro's clearly stated initial assumptions that the primary role of the State is the reproduction of the capitalist system of production determines the explanations of health policy that follow.

According to Navarro the class structure of society explains both the nature of medical care and the form of national health policies. He identifies the nature of medical care as 'the individualisation of a collective causality that by its nature would have required a collective answer'.[34] This particular medical ideology, according to Navarro, was developed at around the same time as the Industrial Revolution and served to distract attention away from what Navarro claims were the real causes of deteriorating morbidity of the population, poor working conditions, at the same time as it elevated the status of the medical profession.

As for the form of policy, Navarro identifies two types of State intervention in the health arena; what he calls negative intervention, where the State prevents the adoption of policies likely to threaten the class structure of society. As an example he gives the creation of the NHS in Britain, which he argues was created in response to demands which threatened to destroy the status quo.

Navarro describes as positive intervention State involvement in the financing and administration of hospitals, the passing of safety regu-

lations and the promotion and creation of health insurance organisations. This type of intervention according to Navarro is largely the result of pressure group action by the dominant class and results in reforms that tend to serve their interests. Navarro gives the 'Health Insurance' system as an example of this. He argues that it was not introduced in order to increase access to health care, but rather to shift the cost for maintaining a healthy workforce from the producer to society as a whole. Nevertheless Navarro concedes that even within a capitalist society the working class can achieve positive reform as a result of their struggle.[35]

While Navarro is surely right to argue that health policy should not be considered in isolation from its context, and that the sum of the whole does not necessarily equal the parts, the aim of the analyst should be to develop broad explanations and theories on the basis of the evidence drawn from an analysis of parts of the whole, rather than to seek to explain policy in terms of a predetermined framework, no matter how uncomfortable the fit with reality. It may be necessary to admit, as Klein does in his analysis of the National Health Service (NHS), that no one approach supplies a suitably sophisticated explanation for what is a highly complex organisation.[36]

A second criticism of Navarro's approach is that if one accepts that the capitalist mode of production in all its various forms is dominant in western industrialised countries, then the type of broad generalisations suggested by Navarro tell us little apart from what we already know. It is clear that within this category there are a variety of different types of government and social organisation. Resources are allocated differently, and different actors play more or less important roles in

influencing policy choices. If in the final analysis all these differences are insignificant, and policy outputs all serve the function of preserving the capitalist mode of production, then detailed analysis rather than generalisations is required to show this. If this is the case, the detailed and frustrating business of comparative political analysis will have been shown to be pointless. This is not as yet the case.

From the same school of thought, Alford provides a more convincing and useful explanation of policy. Like Navarro, his aim is to provide a general explanation of policy, but unlike Navarro he develops his theories from detailed analysis of the process of decision making. As a result his analysis presents a more complex and realistic division of interest in society.

The starting point of Alford's analysis is the observation that the American health system is in crisis despite the increasing proportion of Gross National Product (GNP) that has been devoted to it over the years. He contends however that this 'crisis' is not new, and is in fact a symptom of the existence of competing interests that have always been present and which exist in a variety of policy areas. According to Alford, 'advertisements of crisis serve as political weapons in the hands of interest groups inside and outside of government, which divert resources and services from one programme to another, one social group or class to another'.[37]

Alford's main hypothesis is 'that the principal barriers to health care reform lie in the powers of the strategically structured interests, and that this view of the politics of health care provides a broader explanation than one which focuses on specific innovations or pieces of legislation

such as medicare'.[38]

Crucial to Alford's analysis is the distinction he makes between interest groups which are formally constituted organisations with specific but limited aims, and what he terms 'structural interests' which he defines as:

> More than potential interest groups which are merely waiting the opportunity or the necessity of organising to present demands or grievances to the appropriate authority. Other, structural interests either do not have to be organised in order to have their interests served, or cannot be organised without great difficulty.

He further defines structural interests as those interests served or not served by the way they fit into the basic logic and principles by which the institutions of society operate.[39]

Following on from this definition he identifies three types of structural interest. 'Dominant interests' are those served by the structures and institutions of the State, and 'repressed structural interests' are interests which are excluded by the existing institutional structure of the State.

According to Alford, the medical profession is a classic example of a 'dominant interest', which he calls the 'professional monopolists. But he also identifies a challenging structural interest produced by the changing nature of medical care, which he calls the 'corporate rationalisers'. These are the hospital administrators, health planners, and health insurance administrators, that are required by the new style of medical care. The third structural interest identified by Alford in this field is 'community population', or the consumers of health care.

Alford argues that although conflict clearly does exist within the category of 'professional monopolists' the group as a whole is united in defence of the status quo, especially the clinical freedom of the doctor, and the autonomy of the profession. Similarly, while differences exist between 'corporate rationalisers', they are united by their ultimate goal, which is to increase their control over the medical profession and the allocation of health resources in general. As a result, professional monopolisers and corporate rationalisers are in continuous overt or covert conflict but, Alford argues, both have an overriding interest in continuing the system. According to Alford it is the institutional structure of the system which ensures that the corporate rationalisers do not dominate the professional monopolists, and not as pluralist theory would have it, the high esteem in which the medical profession is held by society. Thus Alford writes, 'Rather than a societal consensus giving the doctors power, it is the doctors' power which generates the societal consensus'.[40]

Using this conceptual framework Alford constructs a convincing analysis of the health policy crisis. His analysis of health policy, like that of Navarro, is a Marxist one. He concludes that the impasse, or crisis in the health policy area is a result of wider structural interests within society, and he describes policy developments in terms of struggle between groups within society. However, unlike Navarro, this analysis stems from investigation of specific policy issues, and research which identifies and shows how the 'structural interests' identified interact in producing policy outputs, and ultimately maintaining the status quo. For this reason the concepts developed by Alford are particularly useful. As Alford is seeking to explain aspects of policy making in general and not just policy making in the USA, it should be possible to identify

the same structural interests and to explain policy makers' reactions to the health policy 'crisis' in France in the same terms.

3.vii. **Incrementalist Health Policy.**

One of the limitations of Alford's approach, a limitation he recognises, is that it does not help to explain specific policy programmes, or the degree of involvement and immediate objectives of the various actors involved in these programmes.

David Allen's analysis of the 1962 hospital plan concentrates on one such specific programme and seeks to analyse and describe the role and objectives of those most closely involved with the policy.[41] According to Allen the way in which UK hospital policy in 1962 was decided by the Ministry of Health and the Conservative government of the day provides a good illustration of the incrementalist theories of Lindblom. Thus he writes:

> The action taken is close to the status quo, it results from the examination of means rather than ends. Decisions are the result of continually evolving policy, attempting to correct ills, based on consensus about what has to be done, with little or no analytical assessment about the utility of choice'.[42]

Allen argues that the 1962 hospital plan became policy as the result of a combination of factors. Firstly during the fifties the policy problem was brought to the attention of decision makers and a growing awareness developed among the medical profession and health administrators who recognised that existing hospital infrastructure no longer coincided with the needs of modern medicine. This coincided with a period of relative prosperity for Britain. These two factors produced a consensus that

'something had to be done', witnessed by the fact that both major parties included pledges to invest in hospital building in their manifestos for the 1959 elections. Thus Allen contends that the conditions were ripe for a policy of hospital building. The presence of certain individuals willing and able to seize this opportunity was, according to Allen, crucial. 'Their contribution was that they grasped the opportunity when others might have missed it and they stamped their personalities on the plan'.[43]

Whether or not the health policy 'crisis' is a function of competing structural interests, it is still important to understand why a particular problem reaches the political agenda at a given time, and how and why decision makers come to select one or more policies in reaction to the identified problem. Allen suggests a combination of factors to explain the case of the 1962 hospital plan. But the factors mentioned above are by no means exhaustive. Any of the important variables affecting policy discussed in chapter one could provide part of the explanation of specific policy decisions.

The main weakness in Allen's approach is that it suffers from what Allison would describe as a large 'analysis gap'. Allen's analysis goes only as far as the decision to allocate resources over a ten year period[3] He does not analyse the implementation of this policy, perhaps the most important part of the process. Here we would like to know what type of hospitals were constructed. Where were new hospitals sited? How were these decisions taken? How and when was the money spent over the ten years, and what effect did this have on the problem to which the policy was a response? What part did the medical profession, local authorities, trade unions, and the construction industry play in the process? These are important questions which Allen does not attempt

to answer. The analysis of hospital policy making in France in chapter eight addresses many of the issues dealt with by Allen. Thus it attempts to explain why the policy was adopted when it was, what were the policy problems it was designed to deal with, and which actors provided the main moving force, and finally what was the policy adopted. But it also analyses the implementation of that policy, and asks how this was affected by the policy process, by the actors involved in its implementation, how policy evolved over time, and the extent to which the changing objectives were met by the policy. Whether the policy was incremental or not is only one of the interesting issues here. Other relevant questions are, how does hospital policy making compare with other policy arenas in France? Are the actors involved the same as in other policy arenas? How does the reputedly centralised French local administration affect implementation? Are the local actors the same as those involved in other policy areas? Implementation is thus a crucial stage in the process, and one that must be explained for a full understanding of the complexities of policy.

3.viii. **Health Policy Implementation.**

A recent issue in political science literature has been the idea that policy makers or elected leaders are increasingly incapable of controlling the enormous machine that modern governments have become.[44] This trend is particularly evident in the literature on health policy, where the inexorable rise in the costs of health care and the apparent inability of governments to control these costs has been the subject of much attention.[45]

Frank J. Thompson's analysis of a variety of health programmes in the US goes against the grain in that it provides a far more optimistic

outlook, dealing as it does with a number of successful policy initiatives. Thompson's analysis covers both the policy making and implementation process in terms that relate to existing political science and administrative theories. The approach adopted by Thompson, like the approach of this thesis, is based on the assumption that 'the development of more general policy theories depends on understanding the dynamics of specific policy areas', and that 'broader theories of government regulation must be grounded in the study of a host of policy areas'.[46] Behind the analysis of the various policy areas selected by Thompson is a clearly stated and interesting conceptualisation of policy. According to Thompson, policy can be defined as a hypothesis which 'specifies that if a, b and c are done at any one time, then x, y and z will result at time two'.[47] On this basis, he argues that policies can be distinguished in terms of the plausability of the hypothesis, the extent to which the hypothesis is based on sound assumptions, the precision of the hypothesis, and the extent to which the objectives, resources, means and timetable of a policy are clearly indicated. This approach to policy is very close to the ideas developed by Majone, who argues that one major criterion on which a policy should be judged is the soundness or otherwise of the theories and assumptions on which it is based.[48]

The process of implementation which is defined by Thompson as the 'activities involved in carrying out a policy, or putting a programme into effect' is influenced by a wide range of factors, ranging from bureaucratic rules and regulations to the political and cultural characteristics of a country. Thus Thompson argues that implementation should be seen as 'the extension of the political process to the health bureacracy. A variety of actors engaged in strategic behavior and following routines influence the nature of program output and outcomes. The statute itself

is obviously one factor, but there are other pivotal factors as well. Variables related to the program's bureaucratic niche, its political environment, and its interaction with oversight actors are also as important'.[49]

Thompson next explores a number of reasons why policies fail to achieve their objectives; what he calls 'policy pitfalls'. The explanations he comes up with include the overstepping of authority by civil servants, delay in implementing policy, which may be equivalent to the non-implementation of policy, and the cost of policy, amongst others. He argues that a variety of factors tilt the policy towards one or other of a variety of pitfalls. As an example from the area of health, Thompson points to the Medicaid policy and argues that the precision of the initial statute on Medicaid helped avoid delay and goes some way to explaining its success, while the imprecision of the health planning act goes a long way to explaining its failure.[50]

From the evidence drawn from his case studies, Thompson reassesses and questions a number of accepted 'truisms' of policy theory. Thus he argues that commitment can be counterproductive if it results in policy makers continuing to fight a policy battle long after it is clear that the cause itself is lost.

The lesson of Thompson's analysis of health policy making is that a more nuanced interpretation of implementation may be necessary. It is easy to dismiss a policy as having failed to meet its aims and to explain this in terms of bureaucratic inefficiency, or the paralysing complexity of competing demands and pressures placed on today's policy makers, but before this can be done one must be clear exactly what

those aims were. If we accept the definition of policy given at the beginning of this chapter, then the real objectives of policy may be very different from those set out in planning documents or official declarations. It is easy to blame non-implementation, or the inefficiency or unwieldiness of the bureaucracy, but non-implementation takes a number of forms, and may be explained by a number of factors. This is the approach adopted in the analysis of the implementation of hospital policy in France in chapters 8 and 9. Like the policies analysed by Thompson, the implementation process here can and must be judged on a number of criteria. On this basis it would seem reasonable to assume from the outset that on certain of these criteria it will score badly, and on others better.

3.ix. **Health Policy - a special case?**

Does the health policy arena differ from other policy fields? That there are certain characteristics peculiar to health policy making is beyond question. It is by no means clear however that health policy making is fundamentally different from other policies. The apparent inability of governments to control the escalation of health spending has led some to suggest that there is something unique about this area of policy, but it may equally be presented as just another example of the phenomenon of 'ungovernability', a feature of all modern industrialised nations. The medical profession clearly plays an important part in the health policy making process, but whether this is a result of the nature of the services they provide, or another example of the more general phenomenon of new technological elites is by no means clear. Is it the fact that the product 'health' is both highly valued, and unmeasurable, that confers exceptional powers to the providers of this service? Or is the influence of the profession due to the existence

of an extremely well organised union? The measurability of the health care does not seem a convincing argument, for if we consider the 'outcomes' rather than outputs of, for example, education policy, these are equally unmeasurable.

The various authors analysed above show that depending on their approach, different answers are possible to these questions. I have argued that in order to fully explain policy a combination of these approaches which combines an analysis of the broad patterns of policy making as well as the specific policy programmes is necessary. Thus in the analysis of health policy making in France that follows, two contrasting policy issues will be analysed in depth: the 'Convention Nationale', the tariff agreement between the insurance funds and the medical profession, which also forms the basis of primary health care policy in France, and the 1970 Hospital Law, a one-off reform with limited but clearly defined aims and objectives.

To be able to answer the question 'does the health policy arena differ from other policy arenas?' to our complete satisfaction, it would be necessary to compare and contrast our findings with similar studies of other areas of French policy making. In the absence of any such studies, comparison with existing theories on policy making in France and policy making in general, as discussed in the previous chapter, will have to suffice.

3.x. **Conclusion.**

It is clear that a number of eminently justifiable reasons for studying public policies exist. Policy may be studied in response to a demand for greater information on government actions and the effect of these

actions. Policy may be studied as part of a search for better policies. An analyst may concentrate on policy in a search for theoretical comprehensiveness, and policies may be compared in order to isolate generic or specific explanations of policies. In the approach adopted here the object is not policy, for the sake of policy, but an attempt to explain how a given political system works. The existing literature on the French political system has tended to concentrate almost entirely on the institutions of that country, and especially on the role of the President. The main issue has been the degree of power held by the President, with a variety of sub-issues involving the administrative élite and central/local relations, which are very much variations on the same theme. This has been carried out in a virtual policy vacuum. As a result the main conclusion that can be drawn from the literature is that the political system is highly complex, and hence the impossibility of providing any one satisfactory explanation or model of the distribution of power in French society.

Policy analysis suggests that there is a way, if not of overcoming this complexity completely, then at least of simplifying it. In the preceding chapters I have sought firstly to define the concepts involved and secondly to identify the main variables influencing the process. The definitions of course differ, as does the emphasis placed on different variables by different analysts. What is clear however is the importance of clearly establishing the basic assumptions and definitions before any attempt is made to describe policy. As Allison has so clearly illustrated initial assumptions play an important part in determining explanations of a given event.[51]

In the approach adopted here my initial assumption was that the French

political system is a complex and contradictory reality. In order to understand this complexity it is necessary to simplify it artificially by looking at specific policies. This does not mean that I assume that the whole can be equated with one of its parts, or even the sum of its constituent parts, but rather that the whole cannot be comprehended without a full understanding and knowledge of these parts. Secondly, in order to comprehend the whole, we must start by understanding what we are analysing. Hence the attention in the previous chapters to defining policy, and categorising broad explanatory factors.

By analysing one policy area it becomes possible to draw conclusions about the French political system that much more confidently.

Rather than claiming that power in France is held by A, B or C, it can be argued that power in the area of health policy is held by A, B or C. In contrast to broad theories about the political system as a whole, which can always be contradicted by reference to specific examples, analysis of 'outputs' in well defined limited policy areas can produce conclusions which are less easily refuted.

The aim of the approach adopted here is neither to confirm nor to reject the accepted theories on French government and politics. Instead I expect to find that these theories are in some instances the most appropriate if not the only explanation of policy at a certain level. But as some of the assumptions of policy analysis pose different theoretical questions, I expect to find that some new insights will be provided. Nor do I intend to offer any general theory about policy making in France. Health policy making is one small part of a very large whole. It would be extremely rash to attempt to predict the overall pattern on the basis

of policy in this small area. A comprehensive study or series of studies covering a number of policy areas may on the other hand provide the basis for a more satisfactory model of the French political system. Thus the first step towards explaining the process of policy making is to explain the context of that policy. Policy is not made in a vacuum. The incrementalist approach to policy holds that the best way of understanding policy is by looking at policy in the year x-1. This in a way is simply avoiding the question, as one would presumably want to explain policy in the year x-1 as well. It is therefore necessary to go back further and to analyse the history and development of a particular area of policy. The reason for this is that it provides some of the answers as to why a particular issue reached the policy agenda, as well as the institutional context of a problem. This in turn determines to a certain extent how the problem is dealt with, and the constraints placed on the decision maker. The aim in chapter four is to set the scene by describing the historical development of health policy in France and the institutional context within which the policy makers act. 'Ideas' and institutions are two of the concepts identified by policy analysts as explanatory variables for policy. In chapter four I also examine the complex interaction between the ideas of 'la médecine libérale' and the institutions for the provision and financing of health that have been developed in France during the 20th century.

Again the reason for this is the significance for the policy process of these 'ideas' and their relationship with the institution for the provision and finance of health care.

In chapter five I set out the structure of the French health system and describe its constituent parts. Put in the terms of the policy analyst,

I identify the inputs and outputs of the system. I also provide a brief analysis of the particular form taken by the health policy crisis in France and describe in general terms the types of policies that have been implemented in recent years in attempts to resolve these problems. This broad overview is necessary in order to understand the general context before moving on to more detailed analysis of specific policies in the case studies that follow.

One of the principal assumptions of this study is that in order to study the process of decision making, it is necessary to simplify the system under examination into its component parts. The reason for this is firstly the complexity of modern government, and secondly the hypothesis that in different policy areas, different actors and different institutional structures are involved, and that these have a considerable bearing on the policy process.

In chapter two I have discussed the different categorisations of policy that have been used by policy analysts and which represent different methods of reducing or simplifying the complexity of the phenomenon under consideration. I have also justified the choice of the substantive policy area of health. However, as the focus of attention is switched from general broad analysis to specific and detailed analysis of parts of the system, so complexity again becomes a problem and it becomes necessary to further refine the definition of policy and to select specific policy issues to serve as tracers through the system.

It would be nice to be able to say, paraphrasing Gertrude Stein, that 'health policy is health policy is health policy'. Unfortunately there is no clear body of doctrine from which a precise and unequivocal set

of objectives, clearly identifiable as 'health policy', can be drawn. Of course Government Ministers periodically make statements about health policy, and reference to health programmes may even appear in party manifestos, but the definition of policy used here carries a far wider meaning than this.

The health policy area is itself a highly complex and contradictory field. In order to explain it satisfactorily it is necessary to explain policies that capture its full range and complexity. Thus it is necessary to further refine the definition by categorising policy as either implicit or explicit. Implicit policy is the most difficult of the two concepts to grasp. It does not follow on from government legislation, parliamentary debate or bureaucratic commission. It is by definition incremental, in that it assumes an acceptance of only marginal alteration to the status quo. Policy is implicit because although it may be justified and its objectives stated, its implications and significance run far wider. This differs markedly from what I have called 'explicit' policy, and it seems reasonable to assume that so too will the process of policy making. Here decision makers' intentions to reform the system are clearly and publicly announced, the reasons spelled out and objectives stated. The progress of explicit policy can be clearly traced from the commissioning to the publication of a report, from the drawing up of a draft law to parliamentary debate and vote, and from the issue of decrees to their effect on the ground.

Chapters six and nine highlight the different processes that are involved in the two categories of policy outlined above. In the first case study, the system of the 'Convention Nationale', the tariff agreement between the health insurance funds and the medical profession, which

forms the basis of the primary health care in France is analysed. The wider implications of this apparently simple financing arrangement are illustrated in the following chapter.

Chapters eight and nine deal with the formulation and implementation of the 1970 hospital law, a classic example of an 'explicit' policy. In both of the above case studies the aim is to explain the policy making process with reference to both the policy literature and the literature on French government and politics. Thus in each of the chapters on the decision making process, issues such as the 'power of the President', the 'role of the 'Grands Corps', and the influence of pressure groups, will be addressed. The chapters on the implementation of the policies provide the opportunity to assess the role of the Prefect, the Mayor and the local 'Notables', and the degree of centralisation in the field of health policy.

In the concluding chapter we assess the explanatory power of the policy based approach to French politics. The main hypothesis which I will defend here is that in a given policy area specific actors and specific institutions can be identified, and that these have an important independent effect on the policy process. Understanding the particularities of a specific area of policy within a large complex political system is the first step towards a better understanding of the generalities of the political system as a whole. One way to resolving some of the many contradictions within the literature on French politics is through a policy based approach to the subject.

PART TWO

THE FRENCH HEALTH SYSTEM: BACKGROUND

Chapter Four

THE HISTORY AND DEVELOPMENT OF THE FRENCH HEALTH SYSTEM

4.i. Introduction

The purpose of this chapter is to provide the context and background to the policy issues discussed later. As I have argued in the previous chapters, while the political processes, the issue of power and the activities of pressure groups are the most important and immediate factors in explaining policy, policy is not made in a vacuum, and that in order to understand it, the context of the process must be explained as well as the process itself. The object of this chapter is to show, in the first place, that policies are made and decisions taken in the context of existing institutions, which are themselves the product of previously taken decisions. The existence of such institutions often severely limits the options open to decision makers and determines to a certain extent the nature of the political process. Secondly to show that policy makers are limited by a set of ideas that have been formulated over a long period of time on what the role of the policy maker should be, and on the nature of the policy area and the possibility and desirability of change.

'Ideas' and 'Institutions' are, as argued in chapter two, clearly factors which influence the policy process. However the problem with these two concepts is that they are so closely linked. Generally held ideas about what government should do, and how it should go about things, clearly influences the form of institutions created to fulfill these tasks, but institutions themselves have a strong influence on what are the generally held ideas about the role of government. It may be possible as a result of detailed historical research to determine which came first,

the chicken or the egg, but that is not the object of this exercise. I am more interested in how these two factors have interacted to produce the particular form of the French health system today.

One particular aspect of the French health system is the importance of 'la médecine libérale'. In the first section the origins of the idea of 'la médecine libérale' will be described. 'La médecine libérale' is the keystone of the ideology of the medical profession in France, and their standard in the battle against the introduction of collective financing of health care. It remains an important factor in determining what kinds of policy may be introduced in France today. Another concept, that of 'solidarité', also plays an important part in the evolution of the French health system. The second section deals with the challenge to the dominant ideology of medicine and the increasing influence of this second concept. This chapter also describes the political changes which coincided with the reform of the French health system. In the third section the institutions for the provision and financing of health care that have emerged out of this long process are examined.

4.ii. **Ideas: The Origins of 'La Médecine Libérale'**

To find the origins of 'la médecine libérale', or rather the basis of what seemed the natural way to most Frenchmen of providing medical care in the 19th century, it is necessary to go back to the French Revolution and the effect that this had on the organisation of hospitals and ideas about medicine. Prior to the Revolution, hospitals had been dominated by the Church on the one hand, responsible for most of the administrative functions, and on the other hand, the medical facilities which were run somewhat on the lines of mediaeval corporations in which positions were bought and sold. After the Revolution the Church lost

its control over the hospitals and the medical facilities were dissolved to be replaced by a new system of competitive examinations which were intended to ensure equal access to the profession on the basis of merit alone. The Revolution also produced a number of novel ideas about medicine and the nature of illness. Lebon called for all hospitals to be closed as unnecessary, arguing 'si la révolution finie, nous avons encore des malheureux parmi nous, nos travaux révolutionnaires auront été en vain'.[1]

It was more realistically suggested that a new system of local doctors, the 'prêtres du corps', paid by the State in the same way as priests, be set up as it was accepted that illness and disease could not be wished away, no matter how radical the revolution, but it was believed that patients were better off receiving treatment in their own homes.[2]

If the French Revolution can be seen as a battle of principles, it was also, and perhaps more importantly, a battle of classes which saw the emergence of a new dominant class, the bourgeoisie, of which the medical profession was very much a part. The radical ideas on hospital care and health encouraged by the Revolution were shortlived, and never put into practice. Hospitals remained and continued to play an important part in determining the nature of medicine in the 19th century.

Once the confusion of the early post-revolutionary days was over, the ideas of Lebon, and others like him, were discarded, and the new élite began to establish its position. One of the means to this end were the 'internat' and 'externat', the competitive entry examinations to the higher ranks of the profession. The newly established medical schools, and the 'internat' and 'externat' examinations were designed to replace

the favouritism and corruption of the old medical faculties. The competitive examinations were intended to provide equal opportunities to all irrespective of their social origin. The 'internat' examination still exists today, and has been described alternatively as the 'clef de voûte', or the 'pierre angulaire' of French medicine. In reality these competitive examinations turned out to be the first step in the creation of a system which, if not designed to perpetuate a particular ideology, has come to serve that purpose. Medical professors were put in a position from which they were able to determine not only the content of the courses taught to the rank and file of medical students, but also to select and train the next generation of professors to continue the system.

The 19th century was also the period during which, what Foucault calls 'la médecine clinique', developed. The reason medicine took this direction is very much related to the role of the hospital in medical care after the Revolution. Foucault describes the organisation of the system as a kind of contract between rich and poor. Hospital doctors worked on a voluntary basis, visiting from three to four hours a week. The poor, the only inmates of hospitals, thus benefitted from free medical treatment, but the medical profession benefitted from being able to study the course of diseases, and experiment with different forms of treatment. The hospital served as a kind of natural laboratory. This experience benefitted the wealthy private patient who never visited a hospital for treatment, but whose honoraria in turn enabled the doctor to devote part of his time to charitable work, and whose gifts and legacies covered the running costs of the hospital.[3] It is, however, clear who benefitted most from this contract. Treatment in these hospitals was to a certain extent sacrificed to science.

This 'contract' is the origin of the system that links direct payment of a freely negotiated fee, and the independence of the practitioner, with the quality of the medical care produced as an end result. Although there is no logical connection between the two (it was only later that this was sought), throughout the 19th century the system did produce the desired results. The methodical observation, experimentation and classification of disease, the basis of clinical medicine, produced slow and gradual improvements in the skills and capabilities of the profession, and in the absence of any challenge on the basis of better results, justified itself. The 'internat' and 'externat' examinations ensured the continuation of the system and, as Jamous argues, was justifiable, not on the basis of its theoretical openness, but the 'adéquation de critères de sélection aux nécessités médicales et scientifiques du moment'.[4] The experience gained through the internat system, both in confronting clinical problems in the hospital and through contact with more experienced members of the medical staff of the hospital, ensured a good medical and scientific training.

The hospital doctor however was in a minority. This small self-electing élite, mainly based in Paris, but also in the few large towns which had their own medical schools, was in a position to determine the nature of medical science, and to ensure the propagation of their values throughout the profession. No group or authority existed to challenge this dominance. The condition of the patients in the hospitals was such that they were hardly likely to rebel against their treatment, even if their class made it unlikely that their protests would be noted. Hospital administrators were little better off, and as doctors worked on a charitable basis they had no financial weapon with which to attempt to influence them. The only power likely to intervene was political, and as the hospital

was the responsibility of the commune, this meant the Mayor, and the local 'Notables'. This ensured the influence and independence of the hospital doctor, for in the words of Jamous:

> Le médecin possède un pouvoir politique et social du à son origine de classe, et au réseau d'influence qu'il tisse en soignant les grands et les notables de sa région, ces notables dont il fait lui-même parti, et qui par leurs legs et leurs dons subventionnent les hospitaux.[5]

Up until now I have dealt with the medical profession as though it constituted a united and cohesive force. This was in fact not the case. Great differences existed between the type of medicine taught in the different medical schools, and the conflicts and competition between adherents of different theories were fierce. According to Zeldin, writing about the medical profession in the mid-19th century, 'La médecine en France était à cette époque dans un état de confusion aussi extrême que celui dont souffraient les affaires politiques'.[6] There were also important differences of status between doctors. A doctor with a position in a hospital, and a surgery in a large town, was likely to have a comfortable income. A rural doctor was likely to have a large number of bad debts, to receive low honoraria and payment in kind. Zeldin quotes from Charlton's 'Guide des Carrières' on the advantages and disadvantages of medicine as a career. After pointing out the heavy cost of medical training Charlton warns, 'Certains obtiendront de l'exercice de la médecine un niveau de vie honnête mais la plupart resteront dans des situations dont la médiocrité n'est guère encourageante'.[7]

Thus it cannot be said that the principles of 'la médecine libérale' were simply a disguised mechanism for defending the financial interests of the profession. While this may have been the case for a small minority

of doctors who enjoyed a large and wealthy clientele, it was not the case for the majority of the profession.

However, if the system of direct payment of the doctor by his patient presented little financial advantage to the average doctor, the élite of the profession certainly benefitted handsomely. A Professorship at a medical school ensured the practitioner access to the natural laboratory of the public hospital, enabling him to improve his skills and build up a reputation, which in return attracted wealthy clients to his private consulting rooms. One of the most successful doctors of this period was Philippe Ricord, an expert on syphilis, and personal physician to Napoleon III. One of his waiting rooms (there were four in all) was decorated with paintings by Rubens and Van Dyke. After Alexandre Dumas, he was the most decorated man in France.[8] It was clearly in the interest of doctors like Ricord to maintain the system, and they were in a perfect position to do that as they monopolised the teaching of medicine and the selection of their own successors. The fact that the ideas and values of the day coincided with the type of system they promoted, and that there was no effective challenge to their scientific leadership, merely reinforced their position, and made their task easier. There was no need to justify the system; it was accepted by the rest of the profession and produced the results in terms of scientific progress.

4.iii. **The Status Quo Challenged**

It was only towards the end of the 19th and the beginning of the 20th century that the system for health provision was challenged and that a defensive ideology developed for what had previously seemed the natural order of things. This was the result of two interlinked factors. Firstly developments in the scientific world relevant to medicine

which presented a challenge to the orthodoxy of 'clinical medicine', and secondly, new moves towards the socialisation of the provision of health care. Nevertheless, it took over fifty years, and an important political event, to jolt the French health system out of the 19th and into the 20th century.

As pointed out by Jamous, during most of the 19th century the system of selecting doctors and the style of medical practice faced no effective challenge, and was justified by its results. However, towards the end of the century, doctors on the margin of the medical establishment were making important discoveries relevant to medicine. Bernard, not one of the élite University doctors, made important discoveries in the field of physiology, and Pasteur, a scientist, was developing the science of bacteriology. These were just two of the pioneers in a new trend of laboratory based research. Some attempts were made to accommodate this new trend. Towards the end of the 19th century a number of new chairs in medical research were created, but this proved to be a largely symbolic gesture. For every new chair in medical research, two were created in clinical medicine. The individuals appointed to these posts tended to be traditionalists appointed temporarily while waiting for a suitable chair in clinical medicine to fall vacant. For those inclined to medical research, their past training based on rote learning left them poorly prepared for the task. Finally the logic of the system showed itself to be incompatible with this type of activity. The post of Professor was an honorary title, with no salary attached to it. It was covetted because of the prestige that went with it, and the automatic right to ask and to get higher honoraria from private patients. The financial advantage to a Professor of clinical medicine spending only a small part of his time on unpaid hospital work was obvious. The same could not

be said for the medical researcher spending long hours in a laboratory.

The second new development that threatened the continued existence of the status quo was the emergence of collective financing of health care. Advances in medical science meant that hospitals were becoming increasingly expensive to run and hence less able to survive on charitable funding. Advances in medical science also meant that some treatment could only be provided in a hospital environment. As a result hospitals began to serve a greater proportion of the population. At the same time a variety of health insurance organisations called 'mutuelles', were created by enlightened employers, trade unions or by the Church, to bring the new hospital techniques within the means of the ordinary citizen. These two factors led to a dramatic change in the role of the hospital and to relations between the doctor and his patient. The hospital was no longer the resort for the poor and homeless, but had to cater for a paying clientele from all classes. The simple two-way relationship between the doctor and his patient was complicated by the intrusion of a third party, the health insurance organisation. The insurance organisations were anxious to control the cost of doctors' services as well as the nature of the service provided. This meant that the material conditions in hospitals, which had previously only been experienced by the lower classes, now became visible to a far wider public. As explained by Jamous, they became 'une source de scandale intolérable à partir du moment où les couches sociales supérieures, representant l'opinion publique, doivent .... expérimenter sur leurs propres membres'.[9] The frequent absence of hospital doctors and their condescending and domineering attitudes towards their patients also became an issue.

Faced with this challenge the function of the competitive examinations in the medical schools changed. During the 19th century 'sélection sociale et sélection scientifique coïncidaient'. This became less and less the case as new discoveries changed the nature of medicine. The medical profession closed its ranks, with the 'internat' and 'externat' being used as first and second lines of defence. Thus Jamous describes the 'internat' as being 'dans chaque région, dans chaque faculté, des barrages et des épreuves sociales qu'un milieu local possédant un monopole faisait subir à ceu qui prétendaient en faire partie'.[10]

Collective financing of health care also challenged the traditions of ambulatory medicine. The system of direct payment of the doctor by his patient assumed the free negotiation of the price of the medical service between doctor and patient. In practice this meant that the doctor fixed the price of his services according to what he estimated his patient could afford to pay. The introduction of a third party made that negotiation more complex. Faced by a member of an insurance scheme, practitioners tended to fix their fees towards the higher end of the scale. The insurance organisations on the other hand sought to standardise fees. One solution to this problem, adopted by some mutualist organisations in reaction to the anarchy of the market, was to set up their own surgeries employing a salaried medical staff.

It was in response to this two-pronged challenge to the status quo that the first medical union, the 'Confédération des Syndicats Médicaux Français' (CSMF), was set up, and that Dr Cibrie drew up the principles of 'la médecine libérale'.

Thus the emergence of the concept of 'la médecine libérale' in the

1920's was a response to early forms of socialised health provision, and a reaction to an alternative style of health care, and a new ideology.[11] The four principles of 'la médecine libérale': the free choice of doctor by the patient, freedom of prescription for the doctor, and direct negotiation of fees between doctor and patient, were drafted by Dr Cibrie, a founder member of the first medical union in 1927, and later became enshrined in law with the publication of the 'Code de Déontologie Médicale' in 1945.[12] Throughout this century the above principles have formed the cornerstone of the ideology of the medical profession in France.

The principles of 'la médecine libérale' are based on a number of different and sometimes contradictory arguments. Dr Portes, one of the founder members of the CSMF, argued that when a patient consults a doctor, he is automatically in a weak position. His lack of medical training and the condition which brings him to consult a doctor in the first place make him completely dependent on the medical practitioner. In order to accept this situation, the patient must have complete confidence in his doctor. One of the factors that creates this confidence is the ability to choose his doctor freely. On the other hand in order that the doctor may accept this responsibility with equal confidence he must be free to prescribe treatment as he sees fit. The importance attached to this can be seen in a pamphlet issued by the CSMF which claims 'La liberté des honoraires est une des conditions de leur confiance, donc de l'efficacité du traitement'.[13] Another argument advanced at this time was that the direct payment of the practitioner by his patient re-established a balance of power between the two which would otherwise be distorted in favour of the doctor. Alternatively, it was argued that as medical decisions are highly specialised, they cannot be priced or valued in the same way as other goods or services. Thus the payment

made by the patient does not represent the value of the service provided, but is instead a symbolic way of honouring the doctor. Finally a more pragmatic argument, that direct payment discouraged hypochondriacs, served as a useful incentive for the adoption of preventive measures and encouraged rapid recovery.

Although most of the arguments produced in support of 'la médecine libérale' were formulated in this century, the style of medicine it represented was developed in the 19th century. The idea that the laws of supply and demand should determine the price of medicine seemed natural during this period. There was also an element of social justice in the system. The large honoraria paid by the wealthier classes subsidised the lower honoraria or the free treatment of the poorer classes. At the beginning of the 20th century these ideas were coming increasingly into question, and the nature of medicine was changing so that other more complex justifications for the maintenance of 'la médecine libérale' had to be developed.[14]

The concept of 'la médecine libérale' proved to be a powerful rallying force. As already stated, the profession was by no means united, but the four principles of Dr Cibrie seemed to strike a common chord within the profession and served to unite it against the various attempts made by government to reform the system.[15] This phenomenon can partly be explained by the role of the élite within the profession, who, as we have argued, had the most interest in perpetuating the system, and were in a good position to propagate their own values throughout the rest of the profession. The status of the doctor within society, and the values of that society are another important explicatory variable. The social position and the values of the small-town or village doctor

at the turn of the century were in many ways similar to those of the small shopkeeper, the small businessman, and other liberal professions. The doctor, like the above, was a local 'notable' par excellence. Like the shopkeeper, the doctor was his own boss, with a personal and faithful clientele and subject to no contract or higher authority in his place of work. The doctor's surgery could be compared to a small enterprise, its success dependent on the talent and energy of the individual. Not surprisingly doctors shared the values of this section of society, and were hence hostile to any form of salaried employment or control by a third party. The initiative, vitality and independence of the liberal professions were set against what was seen as the mediocrity, sloth and impersonality of the public sector. The rigidity of bureaucratic control was contrasted with the flexibility of the private sector. The principles of 'la médecine libérale' were presented as not only in the interests of the profession but also in those of their patients. This coincided to a certain extent with the view of the general public. The unions' experience of salaried company doctors in the mining industries, for example, led them to support the medical profession's demands for the right to choose freely their doctor and for the independence of the medical profession from any form of outside control.[16]

It seems therefore that 'la médecine libérale' was a product of certain widely held values which were themselves a product of broader social forces and not just the self-interest of part of the profession. During the 19th century these principles had remained implicit as there was no conflict between the way the system worked and the principles of society at large. Social, economic and scientific changes in the 20th century challenged the basis of the system and the principles were made explicit. These values, and their conflict with new social and economic

forces were briefly but dramatically harnessed by the Poujadist movement in the fifties, which has been described as the last fling of a dying economic order.

During the first half of the century the medical profession enjoyed considerable success in resisting the introduction of collective financing of health care. The first government backed proposals for such a system were based on the Bismarckian system that had been introduced in Germany, and that France had inherited with Alsace Lorraine after the Versailles peace treaty. As mentioned earlier, these were opposed by the labour unions as well as the medical profession, and only became law in 1930 after being extensively revised.[18] The 1930 law accepted the four principles of 'la médecine libérale' in full, and the medical unions had won their first battle. As a result the health insurance organisations were unable to fulfill their objective of covering a fixed proportion of their members' medical expenses. The increases in doctors' honoraria always outstripped the increase in the rate at which the insurance organisations were able to refund their members. The law provided for no central co-ordinating agency for the diverse organisations that provided health cover. Doctors' unions in the departments arranged to fix minimum tariffs to ensure against unfair competition, and to prevent any informal arrangements being struck between individual doctors and the insurance organisations.

The profession employed a variety of tactics in resisting proposals for a generalised form of health insurance. The most obvious form of resistance was through their privileged contacts with their clients. The CSMF also campaigned against the reforms in the press. But perhaps the most effective means of resistance at their disposal was political

pressure. The profession has traditionally been well represented in local and national assemblies. In 1848, forty-nine doctors were members of the constituent assembly, and thirty-four were elected soon after to the new national assembly. In 1871, in the first assembly of the Third Republic, there were thirty-three doctors, and by 1898 this number had risen to seventy-two.[19]

An illustration of the form this pressure took can be found in a letter from Dr Luzuy, an active member of the CSMF, to Dr Gazier, the Minister of Labour responsible for the Social Security reforms in 1932. In response to a government proposal attempting to regulate medical tariffs, he wrote to Dr Gazier as follows:

> Vous avez tort M. le Ministre d'apprendre aux médecins qu'en ce pays la justice et la logique doivent s'incliner devant la politique, car les médecins sont mieux placés qu'aucun militant politique pour prendre le baton du pélerin. Ils vont de porte en porte. Chacun de leurs patients est un électeur. En voulez vous un exemple? Dans le Puy de Dôme, les médecins se sont intéressés à la politique, il y a seize médecins au conseil général, et sur six membres de bureau quatre sont des médecins. Vous pouvez donc être assuré que chaque deputé ira au parlement discuter votre projet, après qu'un ou plusieurs de ses supporteurs médecins le lui aura expliqué en lui faisant toucher du doigt le risque qu'il prendrait en le votant. Vous qui ne craigniez pas de menacer les médecins de la prison, pouvez vous en vouloir aux médecins de vous menacer de lutte electorale? L'arme est loyale, elle a fait ses preuves.[20]

The political instability that reigned during the IVth Republic made this type of pressure particularly effective and helped the medical

profession to resist successfully a series of attempts to reform the system of financing health care. It took the political upheaval provoked by the events in Algeria, the creation of the Vth Republic, a new constitution, and the authoritarian leadership of De Gaulle to resolve the situation. The decree of 12 May 1960 took the form of an offer the profession could not refuse. The details of this offer will be described in the next chapter, but it had the effect of persuading the majority of the profession to sign an agreement with a departmental insurance organisation in which they agreed to abide by a standard consultation fee. According to Hatzfeld, the decree was 'repoussé en bloc, et subi en bloc'. And he described the event as the 'grand tournant de la médecine libérale'.[21]

A statement issued by the secretary of the CSMF at the time offers a striking contrast to the tone of the earlier letter of Dr Luzuy, and is further indication of the dramatically changed political circumstances. Calling for the acceptance of the 1960 decree, he wrote:

> Un nouveau gouvernement arrive au pouvoir. Des méthodes nouvelles. Les Ministres entendent les interessés les uns après les autres. Contrairement aux dernières années, les consultés peuvent s'expliquer librement. On semble retenir leurs objections. Pas toutes. Mais les Ministres 'tranchent'. En tout cas les représentants du corps médical n'ont pas cette impression que leur arrivée dans les Ministères signifie: 'Attention voilà l'ennemi'. Il est certain que des modifications de nos concepts nous seront demandées, sinon imposées dans un esprit évolutionniste. Mais une collaboration nous est offerte. A nous de l'accepter. Mieux de la provoquer.[22]

One immediate result of the reforms imposed by the new government

was that the differences that existed within the profession were brought out into the open. A breakaway union, the 'Fédération des Médecins Français' (FMF), which refused to accept the government reforms, was created. It drew its membership predominantly from specialists and its geographical support was concentrated in the Paris area, the Rhône-Alpes and the Côte d'Azur.

Although it is presented as a considerable defeat for the profession, the convention that the government presented for signature was in fact a compromise, with most of the principles of 'la médecine libérale' respected to a certain degree. The freedom of the individual to choose his doctor remained. The doctors retained their right to prescribe as they saw fit, with the only restriction being a fairly extensive list of refundable drugs drawn up by the social security organisation. Direct payment of doctors by their patients remained although tariffs were fixed at yearly negotiations between representatives of the profession and the social security organisations. Ironically, one of the consequences of this system of financing health care, was that although the individual doctor might have felt that his freedom and influence had been curtailed, the overall power of the profession was increased as collective financing of health care increased the total amount of the resources available for allocation by the profession. This is a phenomenon which seems to be a characteristic of professionalisation in developed societies, as has been argued by R. Klein.[23]

In the hospital sector the conflict between the traditional form of practice and the changing nature of the production of health care, crystalized around the issue of full-time service. With the changing techniques of medical treatment, hospitals were becoming more and more

sophisticated and complex establishments. The type of medical activity performed increasingly demanded the full-time presence of a doctor. The challenges to the traditional approach to medical research were increased by the social security organisations which set up and financed research laboratories of their own. The increasing mobility of the profession and the overseas experience acquired by many doctors during the war created a new awareness of different styles of hospital organisations. Finally the élite of the profession had to some extent been discredited by association with the Vichy regime.

When the Social Security organisation proposed a system of salaried full-time employment for doctors, the profession responded with their own proposals in which the hospital doctors themselves would draw up a rota to ensure full-time medical presence in hospitals and which rejected any move towards the introduction of salaried service. Throughout the IVth Republic the profession was able to resist all attempts at reforming the hospital system. Again government instability explains this 'immobilisme', as well as the fact that hospital doctors were in a strong position to resist any attempts at reform. The 'crise de l'hôpital' was a clearly recognised problem. Numerous commissions were formed during this post-war period to study ways of solving the problem, but like the commissions studied by Alford in New York, they were made up of men with little interest in finding radical solutions to the problem. As in Alford's example, these commissions tended to be dominated by medical professors. Jamous argues that in these circumstances it was hardly surprising that they were unproductive. He writes, 'On leur demande de réformer le système, source de leur pouvoir et de leurs privilèges, celui-même qui leur a donné le pouvoir de réformer'.[24]

Again it was only after the birth of the Vth Republic, and the special emergency powers taken by the government during the first few years of its existence, that reform of the system was forced through. As a result of the 'Ordonnance' of 30 decembre 1958, a new administrative unit, the 'Centre Hospitalier Universitaire' (CHU), was set up, in which professors and hospital doctors served as full-time salaried staff. As a sweetener to the pill and to ensure that the public hospital service attracted the most highly qualified and experienced members of the profession, professors and 'chef de service' were allowed a certain amount of time each week, and the use of hospital facilities to treat their private patients. French hospital doctors, like their counterparts, the English consultants, were bought off with a crock of gold.

The reform itself was the work of an ad hoc committee made up of representatives of the Social Security institutions, the central administration, and young hospital doctors. A new alliance of 'structural interests' marked the end of the unopposed reign of the 'professional monopolists', to use the terminology employed by Alford.[25] The group was chaired by Professor R. Debré, coincidentally (or was it?) the father of Michel Debré, de Gaulle's Prime Minister at the time. As the reform was pushed through by way of 'Ordonnance', there was no debate in the National Assembly. The decision was a veritable 'coup de force', and, in the opinion of its supporters, the only way such changes could have been introduced.

The reforms of the hospital service, and the system of financing primary health care, were a long time coming, and were resisted all along the line by the medical élite. It took the particular conditions surrounding the birth of the Vth Republic for this resistance to be

overcome, and for what seemed at the time like dramatic and wide ranging reforms of the health system to be introduced. With hindsight however, the changes now seem less significant. The principles of 'la médecine libérale' were largely respected by the reformers, the only concession required of the profession was that they agree to negotiate with the health insurance organisations and to respect a fee schedule.

The emphasis on the 'entente directe' or the negotiation of fees between patient and doctor, was replaced by an emphasis on 'paiement direct à l'acte', meaning payment of the doctor by the patient, with the latter refunded by the health insurance organisations at a later date. In the hospitals, the élite of hospital doctors had to agree to become salaried staff, but were allowed to continue to treat their private patients. Given their positions, the only difference resulting from this reform was of a semantic nature. The hospital élite still maintained a monopoly over the provision of hospital care, medical training and research. No attempt was made to introduce some form of clinical or economic control over the profession in the hospital. Thus the 1958 and 1960 reforms may have marked a significant turning point in the health system, but they may equally be interpreted as a move by the profession to pre-empt possibly more radical reforms, and to adjust their position to take into account the inescapable medical, social and economic changes that could no longer be ignored. In so doing, the profession managed to preserve the bulk of their privileges and to ensure their continued influence within the system.[26]

4.iv. **The Institutions - Introduction**

One of the hypotheses set out in chapter one, and one of the basic assumptions of this thesis, is that in different policy areas different

institutional structures come to exist. These institutions have developed over time. Their form is of course affected by the particular political culture of a country, but also to a certain extent by historical accident, by the nature of the policy area, and by ideas about the right and proper role of government in the relevant policy area. At the simplest level we see the contrast between the fact that there is no national health service in France, and a large private sector which has not been the subject of political ideological controversy, which is in strong contrast with the system of education which has for decades, and is still, an important political issue and source of conflict. This contrast has other implications: the role and function of the Ministry of Health, the position of the health insurance organisations, and the status of the public hospital, are all to a greater or lesser extent affected by the absence of ideological controversy affecting this area and hence have characteristics which are not typical of the French administrative and political system. In the following section, these institutions, and how they came to be, are described.

Earlier in this chapter I have discussed some of the ideas about health and medical institutions that were produced in the immediate aftermath of the French Revolution. Many of these ideas were far fetched and impracticable. It soon became apparent, for example, that the plan to abolish hospitals altogether was unrealistic. However, the nature of medicine at the time, and the emphasis given to home treatment by the revolutionary thinkers, meant that the hospital system was to take a particular direction that was not significantly changed until the middle of the 20th century, and of which some vestiges still remain in modern hospitals. The prime function of hospitals became to isolate infectious diseases, to provide shelter and sustenance for the poor and homeless

when they fell ill, and to protect society from the insane. The hospital of the 19th century could be described as somewhere between an asylum and a poor house. The responsibility for the administration of these hospitals was given to the newly formed communes which displaced the Church from the predominant role that it previously played in this area. The hospital in France today remains attached to the commune, a factor that has considerable repercussions for policy making as we shall see in later chapters.

The style of medicine that developed in these hospitals is also relevant to present day policy problems. The hospital doctor was essentially a private practitioner who visited the institution from time to time to observe and experiment. He remained completely above all the financial and administrative problems of the hospital organisation. In the larger hospitals more than one doctor visited on this charitable basis, with each having his own different 'services', with his own patients. This seemed a rational basis of organisation given that part of the purpose of the doctor's visit was to study and experiment with certain pathologies. In the service the doctor had absolute medical control but no administrative or financial responsibilities. The organisation of the hospital around services and the personalisation of these services continues today, as does the separation of financial and administrative responsibilities. The service based organisation is now a major issue in the field of hospital policy, but has been in existence for so long that policy makers' attempts at solving the problem have so far only been tentative.

The issue can clearly be seen in Alford's terms as a conflict between Professional Monopolisers and Corporate Rationalisers. The medical profession has so far been able to maintain the status quo, but hospital

administrators, and the health organisations, argue that this system leads to duplication and waste, and that the financial irresponsibility of the 'chef de service' makes it difficult if not impossible effectively to introduce cost control procedures into a hospital.

Another consequence of the function public hospitals came to serve was the creation of a large and flourishing private sector. As medical techniques developed in the late 19th and 20th centuries, more and more surgical procedures could only be performed within the context of specially equipped establishments. The conditions prevalent in public sector hospitals and their reputation led to the development of a private sector to cater for the wealthier classes. At the same time the growth of the mutualist societies and other health insurance agencies meant that more and more of the working and middle classes became consumers of these advanced medical techniques. Given the choice between the private profit making clinics and the public sector, the insurance organisations tended to respond by creating their own clinics to which they could send their members for hospital treatment. Thus the system became further fragmented with the development of a dual private sector, the private for-profit clinics, run by private companies, often but not always formed by doctors, and a private non-profit making sector run by trade unions, mutualist societies, or charitable organisations.

Thus, by the time the social security organisations were created, there already existed a flourishing private sector. One of the declared aims of the social security was to provide equal access to medical treatment for all. The representatives of the trade unions who were in a majority on the administrative councils of the health insurance organisations, interpreted this as meaning equal access to the best medical treatment

available, and that therefore the health insurance organisation should refund members the cost of treatment incurred in private establishments, The extension of health insurance coverage thus produced an enormous increase in the potential clientele of the private sector, and diverted large amounts of the resources that might otherwise have been allocated to improving conditions in the public sector.[27]

The unions' insistance that equal access to health meant that standards be set at the highest level, suggests that the French see equality in absolute terms. Alternatively the development of the private sector may be explained in terms of the influence of the medical profession and, once again, the inviolable principles of 'la médecine libérale'. The private clinics were seen by the surgeons and specialists who worked there as extensions of their consulting rooms, and thus as essential tools of their trade. In many ways the clinics provided a very satisfactory arrangement for them. They had no responsibility for the administration of the clinics, they simply used the facilities, the hire of which was paid for by the patient. The clinic provided all the nursing and other services for which the patient was charged separately. The independence of the practitioner was complete. But this ideal arrangement depended on the patient being able freely to choose his surgeon and place of treatment without any extra costs. The profession argued that no distinction should be made between the services performed by the doctor in his consulting rooms and those he performed in the operating theatre of a clinic. The support of the mutualists and the unions meant that the issue was soon resolved, and treatment in private clinics was refunded by the health insurance organisations. The consequences of this are still evident today with the existence of a dual hospital system competing for scarce resources. If the private sector had always been small, and

reserved for a privileged section of a society, it might well have been dissolved or ignored in 1945. But the fact that insurance organisations had already opened up the clinics to a wider section of society and that, unlike education, there were no ideological or religious issues involved, the private sector was accepted and has become an integral part of the system.

4.v. **La Sécurité Sociale**

The creation of 'la Sécurité Sociale' and the particular form of collective financing of the health care that it represents is another crucial factor in the development of the French health system and the context within which policy makers move. If 'la médecine libérale' was the product of the classical liberalism that dominated the 19th century, then the social security system in France is the child of the different strands of thought that led to the creation of the welfare state in the 20th century in most developed countries. The French health system somehow combines both the above, in what has been termed a 'costly union'.[28] The principles which inspired the creation of the 'Sécurité Sociale', and the way in which the institutions were created and have evolved, are two other important elements in the jigsaw of the French health system.

The origins of the system can be found in the numerous organisations formed by trade unions, employers, religious or charitable associations in the late 19th and early 20th centuries, to provide insurance cover against accident or ill health. These were inspired by a variety of motives; charitable, reformist, socialist and paternalist, but were essentially the result of the increasing industrialisation of society. In 1889 there were 8,883 such associations in France with a membership of 1,401,679.[29] The first moves by government in this field followed the recovery by

France of the territories of Alsace and Lorraine after the Treaty of Versailles. Under German occupation since 1870, these Departments had enjoyed the benefits of Bismarckian social legislation. After Versailles this presented the French Government with a problem. French administrative and constitutional tradition requires that all parts of the nation be administered in the same way. This meant that either the social system in existence in the two departments be dismantled, or else it should be extended to cover the whole country. Another French tradition, based on legal practice rather than the constitution, is that of the 'droit acquis' which holds that a privilege once acquired cannot be removed (or at least not without difficulty). Thus the government of the day had little option but to start considering ways of extending the benefits of the system to the rest of France. The first proposals were put forward in 1920 but it was not until 1930 that the scheme was finalised, and the 'Loi des Assurances Sociales' passed. By 1935 over 10 million workers were covered by the general regime of health insurance that was created by this law. However, a large number of private or mutualist insurance societies continued to exist and the hostility of the medical profession described earlier, meant that the organisation could never cover more than a small part of its members' health costs.[30]

The institutions created after World War II owed much to the experience of the resistance and the make up of the immediate post war governments. The 'Conseil National de la Résistance' which was called upon to form the provisional government set up after the liberation, published a social programme in which it called for:

> Un plan complet de sécurité sociale visant à assurer à tous les citoyens des moyens d'existence dans tous les cas où ils sont incapables de se les procurer par le travail, avec gestion appartenant aux

représentants des intéressés et de l'Etat.[31]

The aims of the organisation were described by P. Laroque, one of the key figures within the administration responsible for drawing up the plans of the new system, as:

> La garantie donnée à chaque homme, qu'en toutes circonstances il pourra assurer dans des conditions satisfaisantes sa subsistance, et celle des personnes à sa charge.[32]

The 'Sécurité Sociale' was created by 'Ordonnance' after receiving a vote of approval from the provisional assembly on the 4th October 1945.[33] The terms of the 'Ordonnance' reflected the two major concerns of its drafters. Firstly the social aim, to ensure a basic cover for all the population against the main risks of ill health, old age and accidents. Secondly the administrative aims, to create a rational organisation in which all risks are spread evenly over the whole population. This implied the creation of a 'caisse unique' - a single administrative and financial organisation.

The implementation of this project has been a long and complex business with many of the original aims falling by the wayside. The drafters of the legislation had been strongly influenced by the Beveridge Report in the UK and planned to build the system around the three 'U's:

Universality - all the working population were to be covered.

Unity - one organisation to cover all the different risks.

Uniformity - benefits to be fixed.[34]

Another important principle around which the system was based was that of 'solidarité', a concept as slippery and hard to define as 'la

médecine libérale'. The Dictionnaire Robert defines the term as:

> Une relation entre personnes ayant conscience d'une communauté d'intérêts qui, entraîne pour un élément du groupe l'obligation morale de ne pas desservir les autres, et de leur porter assistance.

This seems to come very close to the principle, to each according to his needs, from each according to his ability, as does Rodwin's definition of the term - 'collective action to serve a concept of social justice'.[35] These definitions would seem to imply some form of redistributive social justice. The text of the 1945 law supports this interpretation as it calls for a 'redistribution du revenu national destinée à prélever, sur les revenus des individus favorisés, les sommes nécessaires pour compléter les ressources des travailleurs et des familles défavorisées'.[36] Not surprisingly it is also the interpretation held by the 'Confédération Générale du Travail' (CGT), who argue that one of the functions of the social security is to effect 'du point de vue économique et financier une redistribution partielle du revenu national'.[37] However, it seems that the 'Sécurité Sociale' has never represented a form of national solidarity in the strict sense of the term. From the beginning it covered only those who contracted in by contributing to it and, like any commercial insurance organisation, there were limits to the amount that could be drawn out in benefits.

However, this is not the only interpretation of the principle of 'solidarité' and the role of the 'Sécurité Sociale'. Ex-President Valéry Giscard d'Estaing, on how he saw the function of the 'Sécurité Sociale', wrote:

> La sécurité n'est pas le sécurisme, mais la mise en place partout d'un plancher de sécurité, c'est-à-dire de garanties minimales, aussi

> élevées que possible, au-de-là desquelles s'exercent l'initiative et la responsabilité individuelle.[38]

An even clearer statement of a differing interpretation comes from J.C. Sournia who argues:

> Pretendre que tel (mieux répartir le revenu du pays) était l'un de ses buts, est une erreur historique... Certains ont imaginé ou aspiré à ce but. Ils se sont trompés. Une meilleure répartition de la richesse nationale n'est pas l'un des buts de l'assurance maladie.[39]

The reality is that both interpretations are valid. The institutions were created by a left wing government with quite radical intentions, but as Hatzfeld comments:

> Il semblerait qu'il existât une zone d'ambigüité où se placent un nombre de réformes et d' institutions d'inspiration socialiste et par la suite parfaitement assimilées par un capitalisme qui a su se faire les concessions nécessaires: nous placerions dans cette zone, par exemple, la sécurité sociale.[40]

This analysis is very much in harmony with the Marxist interpretation of social policy discussed in chapter one. Hatzfeld continues by arguing that this change has been gradually achieved by a process 'fait de mille petites choses', and so has not been perceived by the general public. This interpretation would explain the continuing belief in the myth of 'la sécurité sociale, le grand acquis de la classe ouvrière', which is still widely prevalent amongst the unions and the French left.

The first Assembly elected after the war had as its main task the drawing up of proposals for a new constitution, but other business also continued. The assembly was dominated by the left, but the new moderate

party, the 'Mouvement des Républicains Populaire' (MRP), was well represented.

Seats held by the Three Main Parties in the Two Constitutional Assemblies

	PCF	PS	MRP
1st Constitutional Assembly	159	139	150
2nd Constitutional Assembly	150	128	163

The communist, Ambroise Croizat, became the Minister of Labour, sharing joint responsibility for the Social Security reforms with R. Prigent, the Minister of Health, a member of the MRP. Croizat favoured the creation of a single fund to cover all risks, to be administered by a council appointed by the most representative Trade Unions. This would of course favour the CGT, which claimed a membership of 6.5 million at the time and was eight times the size of the CFTC, the next largest union. It would guarantee the CGT control of the organisation. Prigent and the MRP favoured a system of multiple 'caisse' in which the 'mutuelles', with which their party was closely associated, would play an important role and which would be administered by directly elected representatives of the contributors. They hoped this would lessen the communist domination of the administrative councils. A compromise solution was worked out in which the principle of a single 'caisse' was accepted, but which would be run by directly elected administrators.

However, the constitutional proposals submitted to referendum by the 1st Assembly were rejected and new elections were held at which

a more conservative body was elected to try again. G. Bidault of the MRP became provisional President of the Council of Ministers. Croizat remained Minister of Labour, and Prigent, Minister of Health. Again the main function of this Assembly was to draw up new constitutional proposals, but under the impulsion of the administration the work of setting up the new health insurance institutions continued. As a result the principles of the 'Sécurité Sociale' were finally debated and voted by an elected Assembly in September 1946.[41]

Despite this the various conflicts between the different parties over the details of how the system should be organised continued. During this period the central administration relied heavily on the support of the Communist Party for their plan, and on its members in setting up and staffing the newly established organisation.[42]

The conflicts over the form of the new organisation were soon overshadowed by the first of what turned out to be periodic crises of the 'Sécurité Sociale'. The new health insurance system was intended to pay for itself, but soon the initial subsidy provided by the government to set up the fund ran out, while the level of contributions from the participants in the scheme remained far below the cost of providing health care. This was partly the result of the fact that the initial calculations assumed that the self-employed would accurately declare their income and contribute their fair share to the insurance organisation. In a country where tax evasion is second nature, this was a rather unrealistic expectation.

This financial crisis provided the excuse required by the MRP to go back on their earlier commitment to a single fund and to pass a new

law allowing for the creation of a separate fund for the self-employed.[43]

This about turn also illustrated the shift in the balance of power in the new assembly. The MRP had increased its electoral strength in each election since the end of the war. It was a new party which brought together the non-communist and non-socialist forces of the resistance and the traditional supporters of the right whose parties had been discredited by association with the Vichy regime and collaboration with the occupying German forces. By 1948 it was beginning to find its identity and to assert its considerable electoral strength. In addition the Communist Party had lost its position as the largest party in the assembly and was on the point of retreating into the political ghetto it was to occupy throughout the cold war. The brave new world promised by the alliance of left and right, forged during the resistance, had been shortlived. The MRP came increasingly to resemble a traditional conservative party representing the interests and the values of groups like the medical profession.

According to Galant, the independence and the individualism of the French middle classes explains the rejection of the comprehensive insurance system planned by the Administration and the 'Conseil de la Résistance'. Thus he writes:

> La puissance latente des classes moyennes françaises et la pression des groupes et partis qui les représentent, se manifeste dans la résistance à la loi du 13 septembre 1946, résistance qui fut couronnée de succès et qui disloqua la solidarité nationale, sans laquelle la généralisation de la sécurité sociale envisagée par l'administration est impossible.[44]

In short, Galant's argument is that the Administration had drawn up

a comprehensive plan for a health insurance system based on the three 'U's referred to earlier, but that the middle classes through the MRP, by tampering with this plan, destroyed its logic, and in so doing made inevitable the periodic crises that have become a feature of the organisation since its creation.

The result of the 1948 law was that it opened the way for the creation of a number of separate and independent funds for different groups. However, the administrative and organisational structure of the institution remained much the same. 'La Sécurité Sociale' was still a semi-private organisation, made up of decentralised and private units, administered by a board elected by the contributors. However, it is important to distinguish between the theory and the reality of how the system functioned. In theory, the 'Sécurité Sociale' was an autonomous organisation administered by and for its members. In reality, according to P. Flamme:

> Le système ne pouvait qu'aboutir, et avait aboutit en fait à une gestion démocratique en grande partie illusoire, dans laquelle les apparances formelles tenaient plus de place que la réalité des choses.[45]

The independence of the system was in fact limited. The administrative council consisting of employer and employee representatives (two thirds reserved for employees, one third for employers) was responsible for determining procedural rules, voting the budget and appointing the administrative staff of the 'caisse'. The status and powers of the local 'caisse' were in many ways comparable to that of the commune and, as with the commune, the local 'caisse' were subject to a strict 'tutelle' from the Ministry of Health and its representatives. The budgets voted by the 'caisse' had to be approved by the Ministry which could also

revoke certain decisions taken by the councils, and if necessary dissolve them and take over their functions. The Ministry also had the power to veto any of the councils' administrative appointments. Given that the first elections to these councils gave the CGT 60% of the votes cast, and an absolute majority of 109 out of 134 administrative councils, this arrangement was designed to maximise conflict.

The significance of the independent status of the 'Sécurité Sociale' was also limited by the fact that the responsibilities delegated to the administrative councils were limited. The most important policy matter, the ability to determine the level of benefits and the rate of contributions was not theirs, but government's. The only area of real independence was the administrative organisation of the 'caisse'. This was an essentially technical matter, not best served by a political assembly, for this is what the councils were, and of little interest to the general public. Thus Flamme argues, 'Autrement dit, à peine déléguée la compétence était, sur l'essentiel, retenue et rejetée vers l'accessoire'.[46]

One of the consequences of this arrangement was the creation of a system very similar to that later identified by Crozier in the field of local government. The unclear division of responsibilities between the 'caisse' and the Administration, the hierarchical structure of both organisations, and the strict supervision of the former by the latter, provide a classic example of the 'système croisé ou en zig-zag' described by Crozier and Thoenig.[47] This system is characterised by the avoidance of responsibilities and the existence of a network of informal contacts and power centres that ensure the functioning of the system. In this system neither party has the ability to get the other to act, but each has the ability to block the actions of the other by resorting to a strict

interpretation of the regulations. This leads to the development of a game of conflict and compromise. Thus the administrative councils make maximalist demands, knowing thaat contributions and benefits are fixed by the government, and hence that they will never have to implement these. The formal independence of the 'caisse' enables the government to dissociate itself from their failures. The frequently occuring crises can be blamed on the inefficient administration of the communist dominated administrative councils. In this context the administrative staff of the 'caisse' were placed in a difficult position. They were appointed by the administrative councils, and could be sacked by them. Their nomination however had to be approved by the government, which could also call for their dismissal. The insecurity engendered by this situation was not designed to encourage administrative efficiency and initiative. Thus, according to Flamme, 'le directeur idéal n'est pas alors le bon gestionnaire, mais l'habile manoeuvrier qui sait louvoyer entre les deux adversaires dont depend son sort'.[48]

The system of direct elections to the administrative councils of the health insurance funds was finally reformed in 1967 by Jeanneney.[49] The new system that was introduced increased the responsibilities of the 'caisse' but reduced union representation on the administrative councils. This much reviled (by the CGT and the CFDT) system of 'représentation paritaire' gave equal representation on the administrative councils to the representatives of the Labour unions and to the employers. The powers of the 'caisses' were increased at the same time as they were given the responsibility for determining the level of contributions and benefits, but also the duty to balance their budget. The extreme decentralisation of the local 'caisse' was reversed by the creation of three central co-ordinating 'caisses' for the three different risks

(Maladie, Vieillesse and Allocations Familiales). Jeanneny hoped that the strengthened representation of the employers, who contributed the lion's share of the income of the 'caisse', would lead to a more efficient administration and to a more responsible attitude from the administrative councils of the 'caisses'. He also hoped that by increasing the responsibilities of the 'caisse' he would reinforce the perceived separation of government and the health insurance organisations. Finally he hoped that their statutory duty to balance their budget would avoid the need for government to intervene periodically to bail out the funds. As will be seen later, this was not to be.

This short review of the evolution of the institutions of the 'Sécurité Sociale' illustrates a number of contrasts with the traditional centralised Napoleonic Model of the French State. The 'Sécurité Sociale' was created immediately after the end of the second world war. The principles which inspired it and the aims it sought to achieve were the product of the resistance movement which in turn was a reflection of one of two dominant political cultures, described by Hayward, that have always coexisted uneasily.[50] Thus it was created independendent of the State, with an elected administrative council and given a highly decentralised structure. The various reforms introduced since 1945, and in particular the 1968 reform, have watered down these principles, and according to some, destroyed the logic of the system. However, in many ways the basic structure still exists.

Despite repeated efforts by successive governments to solve the 'crise de la sécurité sociale', essentially a problem of devising a way to ensure that the system pays its way, the State has regularly been required to intervene to balance the Health Insurance Funds' budget or to raise

contributions for the same purpose, and hence the independence of the health insurance institutions has remained mythical. However, given that the resources of the health insurance organisations are a proportion of the direct and indirect wages of the working population, and hence an important factor in production costs, and that the health bill of the nation has escalated rapidly in recent years, it is clear that government intervention is necessary and inevitable. The form of this intervention has been largely the result of unco-ordinated decisions at a number of different points. A partial explanation for this can be found in the way the role of the Ministry of Health in the formulation and implementation of health policy has developed.

4.vi. **The Ministry of Health**

The Ministry responsible for health policy is the 'Ministère de la Santé et de la Sécurité Sociale'. This apparent tautology is in fact not as absurd as it sounds. The Ministry of Health is a relatively recent creation and its short history has seen a number of changes of title and responsibilities. It is also debatable whether a Ministry with one of the smallest shares of the official national budget can be responsible for health policy when the budget of the social security organisations alone is larger than the yearly budget presented by the Minister of Finance to the National Assembly.

But the Ministry of Health clearly does play an important part in determining health policy in France, and the nature and limits of its role are best explained in terms of the history of the Ministry.

The nearest approximation to a Ministry of Health, the 'Ministère de l'Hygiène, de l'Assistance et de la Prévoyance Sociales', was created

on the 27th January 1920 after an outbreak of an epidemic of the 'grippe espagnole'. Its main function was to encourage prevention, and its powers included establishing hygiene standards for communal establishments, factories and such like. These origins, and a later concern for the declining population of France which led to the creation of a 'Ministère de la Population' eventually absorbed by the Health Ministry, explain the important role the State has always played in the provision of preventive care in France, but also the limited conception of prevention that their activity implies. This is clearly illustrated by J.C. Sournia, a former 'Directeur Général de la Santé', who argues 'guérir incombe aux médecins, prévenir à l'Etat'.[51]

The creation after 1945 of the 'Sécurité Sociale' posed an administrative problem that has not till now been satisfactorily solved. Social security has traditionally been the responsibility of the 'Ministère du Travail', and indeed on issues such as accidents at work and unemployment benefit, this association seems natural. But as the collective financing of health care became generalised and the 'Sécurité Sociale' began financing a larger and larger proportion of the nation's health costs and actively promoting the expansion of the health sector, so the logic of its attachment to the Ministry of Labour became less evident.

In 1945 a 'Ministère de la Santé' was created, later expanded in 1947 to include responsibility for population. The 'Sécurité Sociale' was attached to the separate 'Ministère du Travail'. This arrangement lasted until 1966, apart from a short interlude between the 3rd February 1956 and 6th November 1957, when an experiment with a 'Ministère des Affaires Sociales' which combined both 'Santé' and 'Travail' was created. This experiment was repeated between 1966 and 1969.

Both experiments were cut short as the new Ministry was proved to be far too large and unwieldy. Health and Labour were divided again in 1969 with responsibility for the social security organisations going to the Minister of Health. However, again this proved only temporary, as in 1974 the 'Sécurité Sociale' was once again attached to Labour. In 1977 a new shake-up led to the process being reversed with the 'Sécurité Sociale' returning to the Ministry of Health.[52] The Ministry then remained unchanged until the takeover of the new socialist government in 1981, and the creation of the 'Ministère de la Solidarité Nationale', which was given responsibility for the social security organisations.

The Ministry of Health, 1969-1979

PRESIDENT	PRIME MINISTER	TITLE	MINISTER	DATE
G Pompidou	Chaban Delmas	Santé & Séc.Soc.	Boulin	June 1969
G Pompidou	Messmer	Santé P'que	Foyer	July 1972
G Pompidou	Messmer	Santé P'que	Poniatowski	April 1973
V G D'Estaing	Chirac	Santé	Veil	May 1974
V G D'Estaing	Barre	Santé	Veil	Aug't 1976
V G D'Estaing	Barre	Santé & Séc.Soc.	Veil	March 1977
V G D'Estaing	Barre	Santé & Séc.Soc.	Veil	April 1978
V G D'Estaing	Barre	Santé & Séc.Soc.	Barrot	July 1979

(Source: Revue Française des Affaires Sociales, No.4. October-December 1980, page 25)

As the responsibilities of the Ministry of Health waxed and waned, so internal services were added and subtracted. As a result one of

the major and persistent problems of the Ministry has been its inability to establish a stable and rational organisation of its internal structure. The 'Directions' that were forced from time to time in response to the changing nature of health and the changing role that the Ministry was called upon to play, were added to or replaced existing 'Directions'. Thus with the growing importance of hospital care, the 'Direction Générale de l'Hygiène Publique' became the 'Direction Générale des Hôpitaux et de l'Hygiène Publique' after 1945. These frequent changes reinforced the tendency noted within the French administration for the 'Directions' to become highly independent and compartmentalised bodies.[53]

The Ministry of Health is fairly small compared to other Ministries but makes up for this by the number and variety of parapublic consultative commissions, and committees that it has created and which cluster, leech-like, around it.[54] In terms of prestige the Health Ministry comes near the bottom alongside such Ministries as Environment and Telecommunications. The Ministry of Health is, clearly, one of the less prestigious of French ministries. It is usually run by a technocrat or a politician enjoying a first posting as a Minister. However, it should not be forgotten that technocrats may become political figures and increase the prestige of their Ministry as a result of their own popularity. This was the case with Simone Weil, whose role in liberalising the abortion laws gave her considerable publicity, and a popularity that survived four years exile in the Presidency of the European Parliament.

A more accurate way of assessing the prestige of a Ministry is by looking at the ranking in the final examinations of the 'Ecole Nationale d'Administration' (ENA), of those students entering the Administration.

The most highly qualified of these students opt to join the élite 'Grands Corps', like the 'Inspection des Finances', the 'Conseil d'Etat', and the 'Cour des Comptes'. From there they tend to go to Ministerial Cabinets, and later to senior administrative posts. The bulk of graduates, however, are recruited by the 'Corps d'Administrateurs Civils'. The most highly placed of these opt for jobs in the more prestigious Ministries like the Ministry of Finance, not just for the prestige of these Ministries but also for the greater earning potential that these Ministries offer. Between 1958 and 1974, the Ministry of Health recruited an average of four graduates of the ENA each year. Between 1969 and 1974 however, their intake increased to an average of ten ENA graduates recruited each year. In 1976 the highest placed of the students recruited by the Ministry of Health was fifty-ninth out of a total of one hundred students and the average position of the twelve students that entered the Ministry in that year was eighty-second. In comparison, the best placed recruit to the Ministry of Finance in the same year was ninth, and the average position of the twelve ENA graduates recruited was forty-third. The results of earlier years mirror this pattern.[55]

D. Ceccaldi and M. Lucas argue that the status of the Ministry has been improving in recent years. They claim that the increasingly important financial responsibilities of the Ministry, and the growth of the health sector, has led governments to devote more attention to this department. The result in their view has been that 'l'image péjorative d'un ministère mineur dans l'échelle des responsabilités gourvernementales, s'efface peu à peu devant ces réalités'.[56] This may be wishful thinking on the part of the authors however, as both are members of the 'Inspection Générale des Affaires Sanitaires et Sociales', and hence

part of the Ministry of Health.

A crucial feature of the Ministry of Health is that it is only relatively recently that it has become involved in dealing with health policy comprehensively, in the sense that it is currently understood. A major part of its work still consists of setting and inspecting safety and public hygiene standards, and of promoting specific health programmes such as infant and maternal health services. It is only since 1945 that a 'Direction' responsible for supervising hospital policy has existed. Yet even so the main function of this direction is vetting the appointment of hospital doctors and administrative staff. The implications of this are that there is no longstanding administrative tradition in this area and no clearly identifiable field of influence as exist in most other policy areas. The restricted role of the Health Ministry also means that no national hospital administration in the sense of, say, the British NHS has been developed. Hospitals are separate and independent units attached to municipalities. In both the hospital sector and primary health care, it is the health insurance organisations that shoulder the main financial responsibility. The Ministry of Health is only indirectly involved as one of a number of central government agencies responsible for supervising health care provision. In the opinion of many of those actually involved in health administration the importance of the Ministry of Health is far outweighed by the Ministry of Finance, which in France, as elsewhere, plays a crucial role in this type of policy.

4.vii. **The Periphery.**

The Ministry of Health, in common with other French Ministries, is divided between the central administration and the 'field services', located in the Regions, Departments and communes. If the history of

the Ministry of Health is a short one, the 'field services' of the Ministry of Health are even more recent creations. The 'Directions Départementales des Affaires Sanitaires et Sociales' (DDASS) were only created after the '1964 Loi de Décentralisation' by the fusion of a number of departmental services dealing with aspects of public health. One of the aims of the 1964 administrative reforms was to enable central government to delegate many of the routine decisions, which traditionally had to be ratified by Paris, to the periphery. C. Gremion claims that the central services of the technical Ministries managed to resist the reformers' attempts to devolve decision making, by arguing that the highly technical nature of decisions could only be taken at the central level.[57] This appears to have been the case with health policy. Decision making at the Ministry of Health remained highly centralised, while in other areas the tendency was towards delegating more routine decisions to the periphery. The role of the field services of the Ministry of Health, as with the field services of other Ministries, is to advise and inform the Prefect and to implement the policies of government in the Department. Much of the work of the field services of the Ministry of Health thus consists of ensuring that health and safety regulations are respected and in administering the various welfare and public health programmes provided by the State. The Prefect is advised by the field services on his tutellary responsibilities with regard to public and private hospitals, and on implementing government health policy in general. Thus, for example, after the 1970 Hospital Law, it was the field services of the Ministry of Health that were responsible for carrying out the survey of existing hospital beds in the Departments and for drawing up estimations of local needs (see chapter nine). However, while the field services have some supervisory role in the area of hospital administration, they have virtually no role in the field of primary care or

the practices of hospital doctors (see chapter seven). These fall within the scope of health insurance organisations.

Once again the structure of the health administration at the local level is characterised by a certain degree of ambiguity. Although the Ministry of Health may have succeeded in maintaining control over local services, the influence of these services over hospitals is limited, and over ambulatory health care almost non-existent.

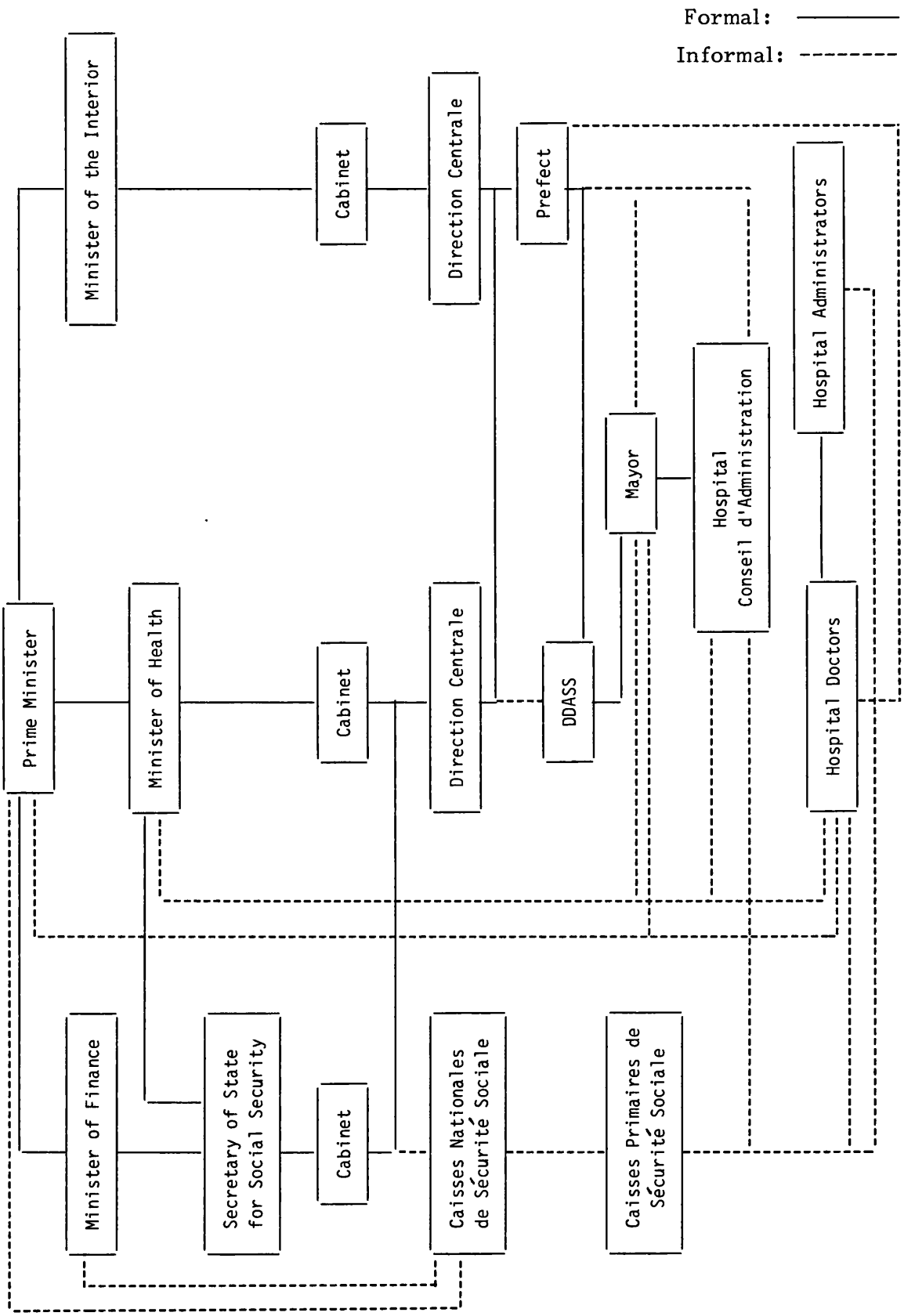
I have suggested above that the organisation of the health insurance system is in many ways similar to the Crozier model for the organisation of local government. Taking a broad view of the health system it is possible to illustrate it in a diagrammatic form similar to that used by Crozier (see figure on p151). However, in the case of Health, the model is made more complex by the presence of an additional vertical chain of responsibilities in the form of the health insurance organisations which makes the distribution of power and the lines of influence far more difficult to identify.

4.viii. **Conclusion**

The importance of the various factors outlined above is that they contribute to our understanding of problems of the health system of France today, and help to identify the limitations placed upon policy makers in their attempts to solve them. For example, the problems of co-ordinating hospital policy in France can be explained by looking back to the creation of independent communal establishments after the Revolution. Similarly the power and influence of the medical profession in modern-day hospitals can be seen to stem from the nature of medicine and medical research during the 19th century and the role of the hospital

Influence and Lines of Communication in the Health Policy Field

(Adapted from: Revue Française des Affaires Sociales, No. Speciale, 60eme anniversaire du Ministère de la Santé, Vol.34, No.4, oct-déc 1980) p544.



doctor at that time. The recurrent crises of the 'Sécurité Sociale' can be linked to the specific form of financing health care that was adopted in France, and the political compromises that were made while the system was being established.

These factors also highlight certain characteristics of the area of health policy. Thus the form taken by the 'Sécurité Sociale' is particularly significant. Unlike the rest of the French Administration which is strongly influenced by the Napoleonic tradition the 'Sécurité Sociale' was the product of an opposing political culture given new impetus by the experience of World War II and the resistance movement. The institution that was created as a result was original in many ways. It is not part of the State apparatus, it is administered by the elected representatives of the contributors or, since 1967, the appointed representatives of contributors, and remains a relatively decentralised organisation. Yet this organisation plays a vital role in financing what in many ways is an important policy area.

The most important feature of the French health system highlighted here, however, is the idea or concept of 'la médecine libérale'. The form taken by the institutions described above can all be explained to a greater or lesser extent in terms of the influence of this concept. However, as we have argued, 'la médecine libérale' did not emerge as an explicit philosophy until after the first steps towards the creation of some kind of system for the collective financing of health care were taken. Thus the influence of ideas and institutions on policy remain inextricably entwined.

The concept of 'la médecine libérale' remains important in France

today as it influences not just the infrastructure of the health system but the nature of health care provided. As an identifiable political culture can be said to exist in France, so there exists a definite medical culture. 'La médecine libérale' is the basis of this medical culture. The importance of this factor for policy makers cannot be over emphasised. In a recent survey, 73% of the population expressed satisfaction with the existing health service.[58] The significance of such a survey and this type of question can be criticised, as they tend to produce similar results in different countries with very different health systems. Nevertheless, this large degree of public support makes it difficult for policy makers to reform the system in any other than minor ways. This poses the question - what and where does the overwhelming degree of public support come from? It might be argued that in this field public opinion is created by the medical profession. Their privileged contacts within the privacy of their surgeries and their professional status makes them well placed to 'create' opinion. But this argument may be irrelevant. If public opinion holds that a given system is good, or better than any known alternative, then policy makers are forced to rule out certain policy options from the start, and to present policy in incremental form. The issue of reform is removed from or rather never reaches the political agenda. Canone and Guyot argue that health became an issue for the first time during the 1978 parliamentary election. However, the socialists then, and once in government, did not attack the principle of 'la médecine libérale' as the basis of the French health system and failed or were unable to raise the most crucial issue, the need to ration medical care.

Chapter Five

POLICY PROBLEMS AND PROBLEM POLICIES

5.i. Introduction

In a stimulating article on comparative policy making, Douglas Ashford argues that the developed countries of the world, broadly speaking, are faced with the same problems, but have adopted a wide variety of different measures to solve them.[1] Health policy is a case in point. After a long period of expansion in the health sector, during which a variety of schemes for socialising the cost of health care were introduced, and where the major concern of policy makers was for ensuring the equality of access to health care, the emphasis has now shifted to controlling the cost of health care. The 'health spending paradox' has become a common phenomenon. The nature of the paradox is that although the developed nations are spending increasing proportions of their Gross National Product (GNP) on their respective health systems, the generally accepted indicators of the health status of a nation show no signs of improving in similar proportions, but instead have been static for a number of years.[2]

Whereas government policies during the fifties and sixties were chiefly concerned with such questions as equal access to health care, policies are now designed to limit medical consumption, restrict hospital construction, and rationalise the allocation of resources in the health sector. However, despite the variety of different types of health system in different countries, the policies that have been adopted have been remarkably similar. They consist of a variety of measures aimed at influencing the demand for, and supply of, health care. The different

institutional contexts in which these policies have been implemented obviously have a significant influence on how successful they are likely to be. The highly centralised British National Health Service for example has been more successful in containing costs than some of the more loosely organised health systems of its European neighbours. However, the similarity of the problems faced and the solutions adopted suggests that health policy has some inherent characteristics that transcend national, cultural and institutional differences.

In chapter one I argue that the health policy field, despite the fact that it is only one small part of government activity, is still a highly complex one with a variety of issues of different kinds and varying importance. The aim of this chapter is to describe the French health system as it is today in general terms, and to identify some of the more important problems facing the policy makers and the types of solution they have attempted to apply. The justification for this is twofold. Firstly, the object is to identify which certain characteristics of the health policy arena are the result of the specific form of health care financing adopted in France, and which stem from the nature of health policy itself. Secondly, this chapter serves as a counterbalance to the following chapters which concentrate on two specific policy issues to the exclusion of all others. The reasons for the selection of these two issues are spelt out elsewhere, but this chapter gives a brief description of other policy problems which cannot be ignored, as well as an overview of the French health system as it functions today.

5.ii. **The Health Spending Spiral**

The health policy problem in France put bluntly is that spending is increasing at a faster rate than GNP.[3] Health expenditure in France

in 1978 came to FF1163.1 billion, an increase of 18.3% over the previous year, compared with the 3 billion spent on health in 1950. Health spending in 1950 represented 3% of GDP, 4% in 1960, 5% in 1970, and 7% in 1977. Since 1963 the rate of growth of health spending in France has exceeded that of the United States and most other European countries. The average yearly increase in spending by the 'Caisse Nationale d'Assurance Maladie des Travailleurs Salariés', which covers the bulk of the health costs of over 70% of the population, has been 20% since 1963.[4]

Health Spending as Percentage of GDP: 1974

United States	7.6	Austria	5.6
Sweden	7.4	New Zealand	5.5
Holland	7.3	Finland	5.5
West Germany	6.9	Australia	5.4
France	**6.9**	Switzerland	5.0
Ireland	6.9	United Kingdom	5.0
Canada	6.8	Belgium	4.8
Italy	5.9	Japan	4.1
Norway	5.6		

(Source: CERC No.48. 2° trimestre. P16.)

The total amount spent by the nation on health is not easily identifiable. The bulk of health spending is covered by the health insurance funds, but other institutions like the 'mutuelles', and private insurance companies, individuals, and central and local administrations also contribute. In 1977 71.4% of health spending was financed by the health insurance funds, 21.5% by households, 3.9% by 'mutuelles', with the

remaining 3.1% covered by national and local government.[5] The international comparisons show that the level of health spending in France is by no means out of the ordinary. Why then the concern? The reason is that it is not the absolute level of health spending that has been the main concern of policy makers, but the rate at which health spending is increasing. This is stressed in the report of the working group responsible for health policy of the VIIIth Plan, as it was in the reports of both the VIth and VIIth Plans.[6]

Evolution of Medical Spending in the EEC (1970 to 1976) as a Percentage of GDP

COUNTRY	1970	1972	1973	1974	1975	1976	Average Annual Increase 1970-1976	
							Medical Spending as %	of GDP
West Germany	5.5	6.4	6.8	7.6	8.9	8.6	17.2	8.7
France	5.9	6.1	6.2	6.4	7.0	7.1	17.0	13.3
Holland	4.7	5.5	5.7	6.1	6.5	6.3	18.5	12.9
Belgium	4.1	4.4	4.7	4.8	5.3	5.7	19.0	12.4
Italy	4.5	5.0	5.0	5.3	5.8	5.5	20.3	16.1
United Kingdom	4.1	4.2	4.1	4.8	5.1	5.2	20.5	15.8

(Source: Le Coût de l'Hospitalisation, Centre d'Etude des Revenus et des Côuts, No.48, 2" trimestre 1979. P109)

A number of factors explain the seemingly uncontrollable rise in the cost of health care and the emergence of cost control as a major policy issue. The creation of the social security institutions in 1945 greatly increased the proportion of the population with access to the health system. The extension of coverage by the system was a slow process, but by 1977 it was complete. As a result 98% of the population now

benefit from some form of medical insurance. The policy of improving the quality of this insurance also contributed to stimulating the demand for health care, and increasing health costs. The system of departmental conventions introduced in 1960, and then the national conventions negotiated in 1970, stabilised and harmonised doctors' fees which enabled the insurance organisations to guarantee the refund of the major part of consumers' health costs. A second factor that has contributed to rising health costs are the advances in medical techniques and science that have been made in recent years. These developments have led to a transformation of the health system. The sophistication of the new technology has resulted in the rapid expansion of the hospital system, and an increasing division of labour within these institutions. The hospital has become a major employer, and the cost and amortisation of medical equipment has become an important part of the health budget. The existence of these new techniques has at the same time increased the demand for health care.

During periods of rapid economic growth these costs may be supported, but in a system in which the resources available for health spending come from contributions deducted from wage packets, economic stagnation with its consequent high levels of unemployment leads in the first place to a decline in the receipts of the health insurance funds while the costs continued to escalate, and also to increasing pressure from employers for a reduction in the level of contributing to the system. In France as elsewhere the fact that the generally accepted measures of a nation's health - mortality and morbidity statistics - have not improved significantly, despite increased spending, has been noted by many analysts.[7] Thus policy makers have become increasingly concerned with the way in which health resources are allocated, and how their

use can be justified. The medical profession has been one of the targets of this concern.

5.iii. **Inputs: Doctors**

Figures published in 1980 by the Ministry of Health show that there were 97,168 doctors serving a population of 53 million in France in 1977, a ratio of over eighteen doctors to every 10,000 inhabitants compared with a ratio of 15:10,000 in the UK. Out of this total 44% of doctors have specialist qualifications.[8] About two thirds of the profession practiced 'la médecine libérale' (compared with 92% in 1954). The decline of liberal practice is a result of the increasing proportion of the profession employed in full time salaried posts in the hospital sector, reflecting the increasing importance of hospital based care over the last thirty years.

In recent years the medical profession has expanded rapidly, and its structure is changing. Between 1972 and 1976 over 10,000 new doctors took up practice in France. Stephan has estimated that in 1980 there were over 100,000 doctors in France, giving a ratio of over twenty doctors to every 10,000 inhabitants. This rapid increase in numbers has considerably changed the structure of the profession and will, according to Stephan, eventually lead the profession itself to call for changes in the way the system is organised as competition increases.[9] Half of French doctors are now under forty years of age. In 1969 only 12% of French doctors were women. This proportion increased to 17.5% by 1975 and among the under forties the proportion is 32%. Stephan has predicted that if this increase in the medical population continues unchecked, France will have twenty-eight doctors for every 10,000 inhabitants by 1995.[10]

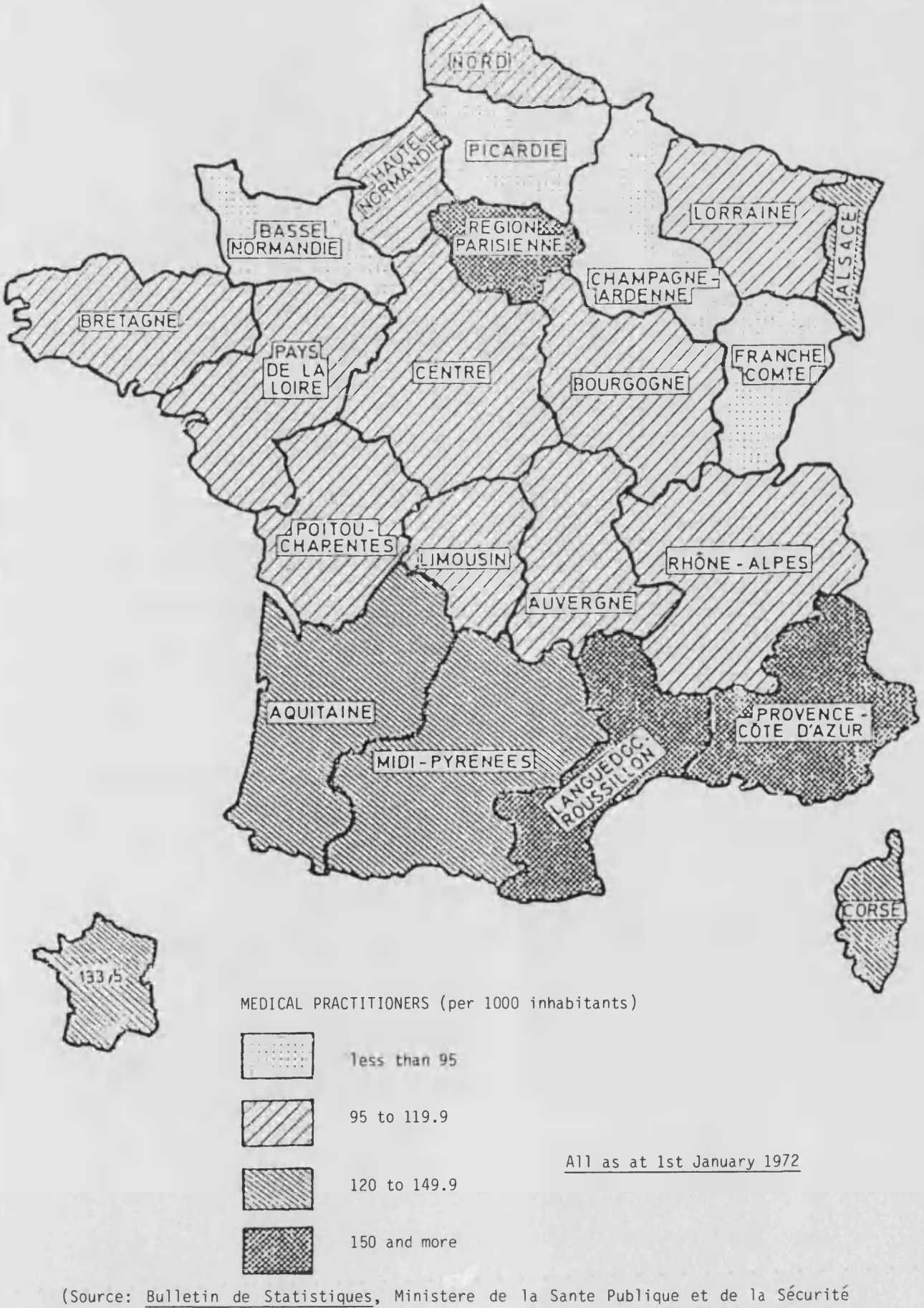
Faced with this rapid increase in numbers, decision makers have been attempting to elaborate measures to reverse this tendency. The problem with elaborating a policy to control the number of doctors entering the market is that it requires the cooperation of the medical profession as a whole, and the university élite responsible for selection in the medical schools in particular. It is only recently that the two medical unions have seen this issue as a problem and have begun calling for government action to limit student numbers. The fact that newly qualified doctors seemed more prepared to accept salaried positions, and showed little attachment to the principles of 'la médecine libérale' goes some way to explaining this change of view. Another difficulty is that the present situation is a result of decisions, or rather non-decisions, taken between seven and ten years ago. A number of reports have recently been commissioned on medical training (cf Fougère report) and reforms limiting university numbers introduced, but the effects of any policy adopted now are only likely to be felt in an equivalent number of years. One of the few options available in the immediate future is to try and persuade doctors to retire early, but this only has a marginal effect on the number of doctors in the system.

Despite this apparent abundance of doctors in France there is still a problem of unequal access to medical care. One of the principal objectives of the creators of the social security institutions was to ensure equal access to health care. With the progressive expansion of coverage of the population by the health insurance funds the financial barriers to equal access to health care have now been removed, though surveys by research organisations and the 'Inspection Générale des Affaires Sanitaires et Sociales' indicate that there are still considerable differences between regions in terms of available health resources, and hence

considerable inequalities in access to health care. However, an analysis of government statements on health policy suggests that this is not one of their major concerns. The explanation for this is partly to do with the fact that the issue of costs dominates the policy agenda, and partly to do with the fact that given the nature of the French health system there is very little the government could actually do about this without bringing into question one of the principles of 'la médecine libérale', that is the right of doctors to set up practice where they think fit. Predictably the highest concentration of doctors can be found in Paris, but the affluence and climate of the Rhône-Alpes and Côte d'Azur regions have also attracted large numbers of doctors. A report by the 'Inspection Générale des Affaires Sanitaires et Sociales' (IGASS) concludes that there is a general imbalance between the north and the south of the river Loire.

Thus in the Picardie region and in the Loire the ratio of doctors to population is 11.4 and 11.8 per thousand inhabitants respectively, compared with an average ratio of 17 per thousand for the whole of France. In contrast the Provence-Côte d'Azur, and Languedoc-Roussillon have respectively 24.2 and 28.7 doctors per thousand inhabitants (see map on following page). These disparities between well and under provided for regions become even more striking as the units get smaller. Thus in the Haute-Saône Department the IGASS found that there were only seven doctors for every 10,000 inhabitants, compared with a ratio of 31:10,000 in Paris intra muros. The report highlights the fact that it is not just the traditionally deprived and underpopulated rural areas that suffer, but also some of the newer suburban developments. Thus in the 'Grande Couronne', the urban sprawl that surrounds Paris, there were only 10.3 doctors per 10,000 inhabitants. These observations led

Density of Doctors by Region



(Source: Bulletin de Statistiques, Ministere de la Sante Publique et de la Sécurité Sociale, No.2, 1973, p28)

the IGASS to conclude that 'il existe en France à l'échelon infra-départemental des petits déserts médicaux'.[12]

An important tenet of 'la médecine libérale' is that doctors should be completely free to set up practice where they choose. In theory the laws of the market should dictate that they choose the area with the lowest medical density, or in any case avoid those areas where the market is clearly saturated. In practice this does not happen. The areas suffering from underprovision are either poor, underpopulated, or have an unpleasant climate, if not all three. Newly qualified doctors are discouraged from setting up in practice in these areas by the high costs of the necessary equipment and by the attraction of the more densely populated areas where, despite the fiercer competition, they are more likely to ammortise their investment. It is clear that the 'système libéral' does not automatically ensure an even distribution of the profession, and that some form of outside intervention is necessary. The nature and form that this intervention should take is less evident.

Central policy makers have had little success in this area. One policy initiative that has been taken on this issue has come from municipalities or departmental assemblies aimed at solving particular local problems. Thus some rural municipalities have offered a yearly allowance to doctors setting up practice in certain areas to supplement their incomes in an attempt to attract the profession to that area. Another method of attracting a liberal practitioner was to supply and equip a surgery for a potential incumbent. Alternatively, some municipalities, created 'centre de santé' in which one or more doctors are employed on a salaried basis (see chapter seven).

The health budget at its most basic level is the result of innumerable decisions made by individual doctors either in the consulting room or in the hospital. Such wider policy considerations as the state of the finances of the social security institutions are not likely to be factors that influence these decisions, and indeed it would be most undesirable if economic criteria were a major consideration in medical decisions. Yet it is being increasingly argued that some form of rationing is inevitable in the health field.[13] As medical technology becomes more and more sophisticated, and as the capability of the profession for curing and treating illnesses is increased, so the need to make conscious and motivated (rather than rational) choices about how increasingly scarce resources should be allocated has become urgent.[14]

One of the results of this awareness has been the increasing concern for cost effectiveness shown by policy makers in a number of countries and by the attempts that have been made to get the medical profession itself to ration the supply of health care. In the United States this can be seen in the introduction of Professional Standards Review Organisations (PSRO). In France a similar system called the 'Tableaux Statistiques de l'Activite des Praticiens' (TSAP) was introduced. Both these policy tools were presented as having been designed to improve the quality of medical treatment by eliminating unnecessary procedures and overprescribing, and not as simple mechanisms for rationing the supply of health care. In France the impact of the TSAP have tended to be limited by the fact that the medical profession has successfully insisted that the system be run by doctors, and by the fact that the profession has tended to be reluctant to discipline fellow professionals (see following chapter).

5.iv. **Outputs: Consuming Health Care**

In chapter two the history of 'la médecine libérale' was outlined and it was argued that the principles of 'la médecine libérale' still form the basis of the French health system. The profession no longer negotiate their fees directly with individual patients, but the other principles are still respected. Thus the French general practitioner or specialist is free to set up his surgery where he chooses. The consumer has the right to decide whether to consult a specialist or a generalist (or both), and in addition can choose between a doctor in private practice, a salaried doctor working in a hospital outpatient department, a hospital doctor in private consultation (the new socialist government has started to phase out private practice in the public hospital sector), or a salaried doctor in a health centre run by a trade union or a local municipality.

The liberal practitioner charges his patients according to tariffs set at a national convention negotiated every five years between the health insurance funds and the professional organisations (the tariffs are adjusted annually to take account of inflation). The patient pays the practitioner directly and is later refunded 75% of the fee by the health insurance funds. The patient may also take out additional insurance from a 'mutuelle' or private insurance organisation to cover what is called the 'ticket modérateur', the remaining 25% of fees not covered by the insurance funds. In hospital outpatient departments or in health centres a special arrangement, the 'tiers payant' or third party payment system exists. Here the patient pays only the 'ticket modérateur', and the hospital or health centre bills the relevant insurance funds. The cost of any prescriptions, laboratory test or X-ray, prescribed by a doctor is refunded in the same way. Hospitals and health centres are usually able to provide all these services on the premises, but the majority

of these procedures are performed by private laboratories and radiologists. A small number of 'pharmacies mutualistes' do exist which provide prescribed drugs on a third party payment arrangement. The vast majority of drugs are provided by private pharmacists in which the full cost of the drug must be paid, to be refunded later.

Doctors' fees are calculated on the basis of a schedule known as the 'Nomenclature Générale des Actes Professionnels', which classifies medical procedures according to a number of key letters. Thus 'C' represents a consultation with a generalist, 'Cs' a consultation with a specialist, 'V' a home visit, 'B' a laboratory test, 'Z' an X-ray examination, and 'K' a surgical procedure. The letters 'K', 'Z' and 'B' are associated with multipliers to reflect the degree of complexity of the operation. Thus, in an example given by Rodwin, an appendoctomy is coded 'K-50' and the removal of an ingrown toenail 'K-10'. No allowance is made for the time taken for a consultation, or for any complications that may occur during an operation. According to Rodwin this system is based on an implicit concept of medical practice which assumes that a physician's activities can be disaggregated into a precisely defined hierarchy of medical procedures, and that this in turn justifies the pluralism and choice that exists within the system.[15]

The value given to the 'actes' in the 'Nomenclature' are negotiated yearly between the medical profession and the insurance funds. As these negotiations are between a monopsony and a monopoly, the results depend to a large extent on the negotiating skills of each party and their ability to call a bluff, but they also reflect the changing balance of power within the profession, and changing policy orientations. If the value of 'K' for a certain medical act is increased more than for

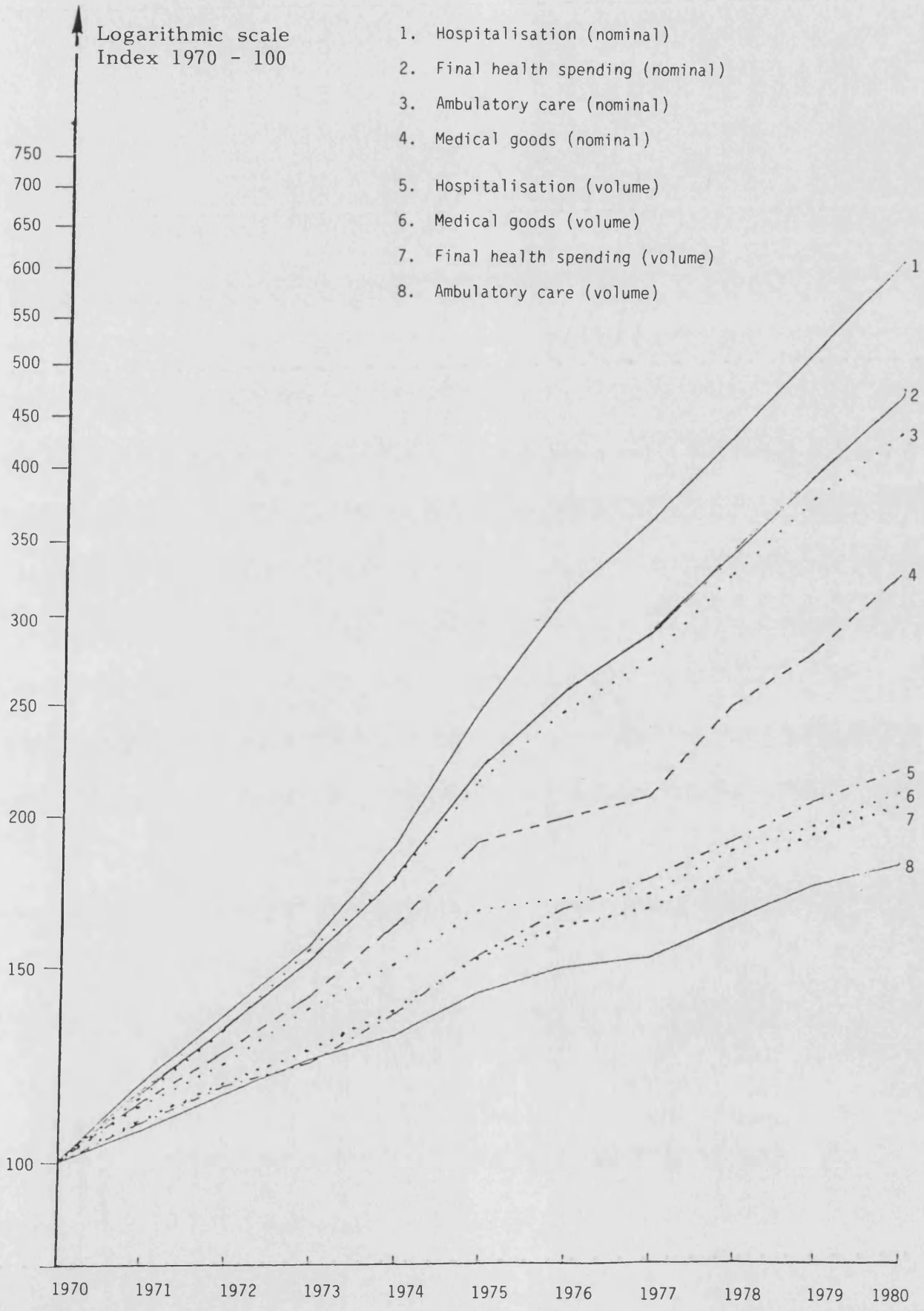
other acts this represents a rise in the possible earnings and hence in the prestige of that speciality - or rather, as the battle is likely already to have been won, the formal recognition of increased prestige. Similarly if recognition is granted to a new speciality it will be quoted in the 'Nomenclature'. An indication of changing policy priorities can be seen for example in the relation between the increases given for 'C', a consultation with a general practitioner, and for 'Cs', a consultation with a specialist. Government policy in recent years has been to encourage general medicine as opposed to specialists. Thus between February 1979 and March 1981 the value of 'C' increased by 25%, in comparison to the value of 'Cs' which increased by 16.5%.

Statistics kept by the Health Insurance Fund on the evolution of medical acts performed as represented by these key letters provide an accurate picture of doctors' prescribing habits (see graphs following). However, as these are not linked to a record of pathologies treated, there is no way of evaluating the efficacity of quality of the medical care being provided. The 'Tableaux Statistiques de l'Activité des Praticiens' (TSAP), a record of all prescriptions made by doctors, are also based on these key letters.

A direct result of this system of financing health care is that the changing nature of medicine has led to a rapid increase in the consumption of certain medical services such as X-rays and laboratory tests. In the last ten years the demand for laboratory analysis has increased by 237%. According to J.C. Sournia, doctors in many cases only examine their patients and attempt a diagnosis after having ordered and examined the results of laboratory tests.[16] Drug consumption has also increased considerably. A number of studies have noted the tendency of French

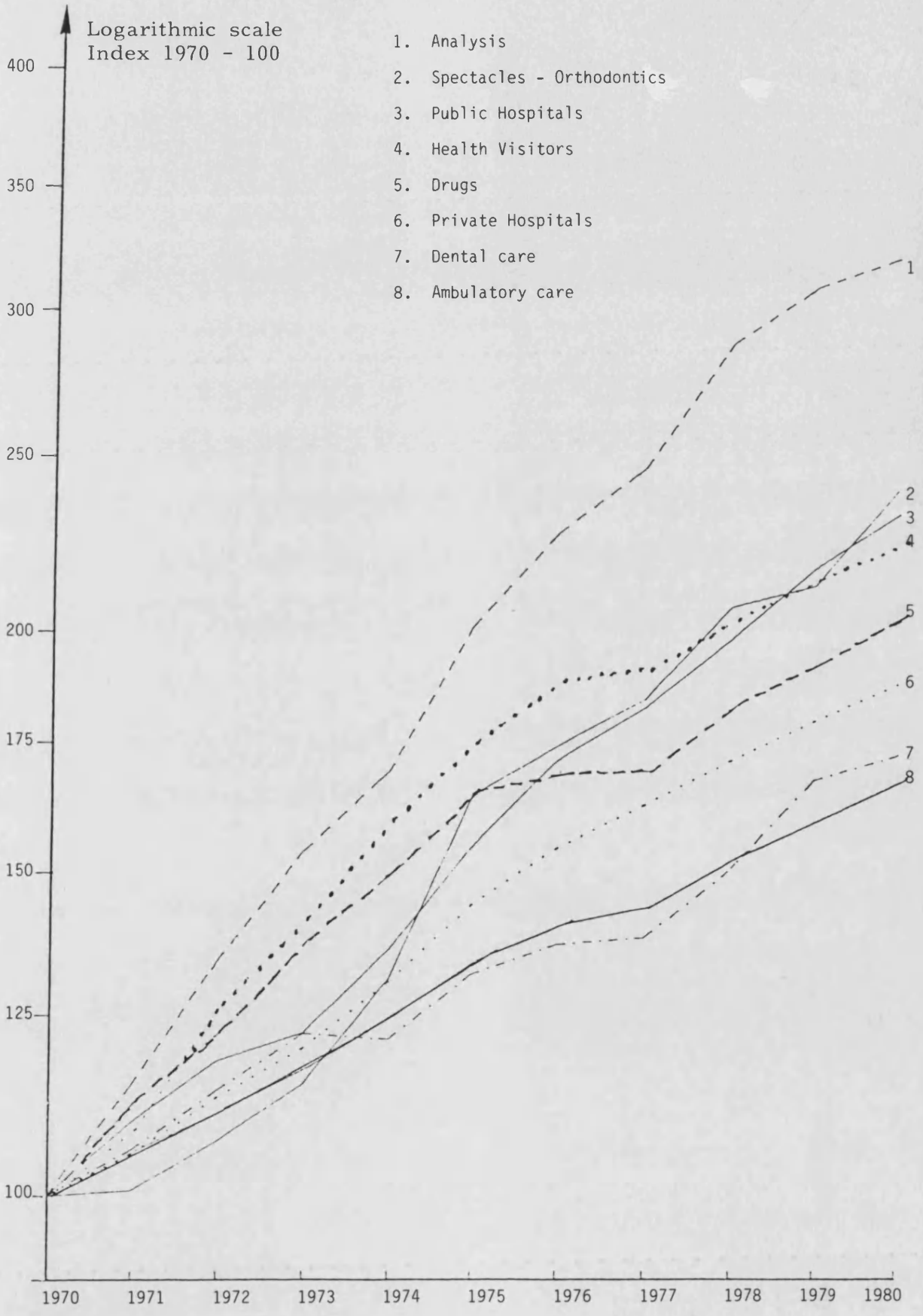
Evolution of Final Health Spending by Category, Cost and Volume

(Source: CREDOC, Les Dépenses de Santé 1978-1980, p62)



Evolution of Health Spending by Activity and Volume

(Source: CREDOC, Les Dépenses de Santé 1978-1980, p65)



doctors to prescribe heavily. A comparative study of France and the USA shows per capita drug consumption in France to be higher than in the USA.[17]

The TSAP have not led to any modification in the practices of French doctors. If the 'norm' consists of heavy prescriptions and the frequent use of laboratory tests and X-ray analyses, and the statistics make no connection between pathology and treatment, then the TSAP are more likely to reinforce existing practices than to change them.

The most direct method available to reduce health costs is by limiting the increase in the value of 'actes' in the 'Nomenclature', in other words restricting doctors' fees. This has undoubtedly been one aspect of government policy, and will be dealt with in detail in the next chapter. However, even this is imperfect as in a system in which a doctor's income is determined by the number of acts he performs, any limitation of the value of those acts can be compensated for by increasing the quantity of acts performed. Thus, paradoxically, one way of keeping down the volume of medical acts performed is to ensure that the annual increases in the value of the 'actes' are satisfactory for the medical profession.

Thus policy makers have an imperfect control of the allocation of health resources. The principles of the 'la médecine libérale' mean that the only way they can reduce health spending is by calling for self discipline on the part of the profession, and by introducing a system of quality evaluation that may indirectly lead doctors into becoming more aware of the consequences of their decisions. The logic of the fee for service payment system and the natural desire of individuals to maintain their living standards tend to negate the various measures taken to

encourage greater economy.

Other system effects are the result of the increasing use of modern technology. Technological improvements may result in greater efficiency, but they tend also to lead to an increase in demand and greater net costs for the financing institutions. For example, where new technology is introduced in an area such as laboratory analysis, significant economies of scale can be achieved, which if not recognised by a revision in the value of the key letter 'B' make laboratory tests increasingly profitable. This makes these procedures more profitable for the laboratories, and consequently results in an increase rather than decrease in the cost for the health service.

5.v. **Inputs: Hospitals**

The difficulties encountered by policy makers in their attempts to control primary health care spending are to a certain extent understandable given that this consists of the innumberable decisions of thousands of individual doctors free of any outside control. However, the problem of controlling hospital spending has been equally difficult. It might be assumed that the size, complexity and cost of these institutions would make them more dependent on central government finance and hence more easily controlled. However, between 1958 and 1978, expenditure on hospital care increased by over 15% per annum, and in recent years that figure has been closer to 20%. Over 50% of the health budget in France now goes towards financing hospital care. As the hospital system has become increasingly expensive to run, it has also become an increasingly important part of the nation's economy. Steudler points out that the turnover of the public hospital system in 1967 was only slightly less than that of Renault (5,557MF compared with 5,855MF).

The public hospital system also employed 300,000 individuals in 1965, making it one of the largest single employers in the country.[18] The control of hospital spending has become one of the main objectives of central government policy (see chapter five), but again the nature of health as a policy, the characteristics of the institutions created to finance the hospital system, and the structure of the hospital system itself, have made this objective difficult to achieve.

The most original striking characteristic of the French hospital system is the existence of a large and dynamic private sector, with free choice for the consumer. The cost of treatment in the private sector is refunded in the same way as in both sectors although the price is calculated by a different method.

There are over one thousand public hospitals in France (including psychiatric and TB clinics), containing 443,311 beds. The private sector is made up of 2,506 establishments of which 722 are non-profit making institutions. The non-profit making hospitals, for example the Red Cross, are in most respects identical to the public hospitals since the 1970 Hospital Law revised their status. The private sector contains 108,169 beds, and because of a faster turnover caters for half of the total number of patient days per annum.[19] The public hospital, despite the transformations that have taken place in recent years, still plays the role of refuge of the last resort for the poor and homeless and increasingly for the aged, that was its main function during the 19th century. A certain number of the long stay beds in public hospitals are used for social rather than medical purposes.

Public sector hospitals are classified according to their size and the

Hospital Resources in the Public and Private Sector

as at 31 December 1977

MEDICAL DISCIPLINE	PUBLIC SECTOR			PRIVATE SECTOR			TOTAL		
	Number of Hospitals	Beds	Ratio: Beds/ Population	Number of Hospitals	Beds	Ratio: Beds/ Population	Number of Hospitals	Beds	Ratio: Beds/ Population
General and Specialist	854	157,499	3.0	710	31,814	0.6	1,564	189,313	3.6
Surgical	488	73,090	1.4	1,235	67,926	1.3	1,723	141,016	2.7
Maternity	573	16,128	0.3	656	13,965	0.3	1,229	30,093	0.6
Convalescence Homes	241	8,026	0.2	466	22,264	0.4	707	30,290	0.6
Functional Re-education	66	4,486	0.1	148	13,317	0.3	214	17,803	0.3
Tuberculosis	78	22,171	0.4	169	12,735	0.2	247	34,906	0.7
Mental Hospitals	213	123,125	2.3	239	16,046	0.3	452	139,171	2.6
TOTAL	**1,072**	**404,526**	**7.6**	**2,494**	**178,067**	**3.3**	**3,566**	**582,592**	**10.9**

(Source: Statistiques de l'année 1979. CMAMTS, Paris. Octobre 1980. P86)

sophistication of their equipment. The largest, the 'Centre Hospitalier Regional' (CHR), have over three hundred beds, provide general care as well as specialist treatment and, in all but one case, that of the CHR of Orleans, are associated with a medical school. The 'Centre Hospitalier' (CH) have between one hundred and three hundred beds and are equipped to cope with general surgery and maternity cases. The last category is poorly defined and contains the smallest hospitals with under one hundred beds. These have alternatively been called 'Hôpitaux Rureaux' or 'Hôpitaux Locaux', and contain only the most basic equipment. The Government has reformed their status on numerous occasions (1970, 1975), with the intention of changing them into social rather than medical institutions, a policy that has had little success because of resistance from local politicians and doctors.

The average public hospital has 240 beds compared with the average private hospital or clinic which has 38 beds. Although the private sector is characterised by its heterogeneity, an important distinction can be made between the private for-profit hospital and the non-profit making institutions like the 'Croix Rouge'. 55% of private beds in France are in private for-profit hospitals. Since the 1970 Hospital Law, which established a system of association, the remaining 44.2% of beds in the non-profit hospitals are in all but name an integral part of the public sector. Private clinics are most frequently owned by a property company and run by a limited company. Doctors working in the clinics are very often directors of these companies.[20]

The public hospital is required by law to stay open twenty-four hours a day, to accept all cases referred to it, to provide an emergency service and, in the case of the CHR, to cater for teaching and medical research.

Treatment in public hospitals is in most cases provided free of charge. The social security institutions pay direct to the hospitals for the services provided on the basis of the 'prix de journée', or patient-day fee. The 'prix de journée' in the public sector in simplified terms is calculated as follows:

$$\frac{\text{Total annual expenditure of hospital system}}{\text{Number yearly of patient-days of hospital system}}$$

The vast bulk of the hospitals' income comes from the 'prix de journée'. Some hospitals, like the 'Hospices Civils de Lyon', have become large property owners as a result of receiving gifts and legacies, but the cost of running a modern hospital makes the incomes from these independent sources insignificant. The 'prix de journée' is calculated annually, and separately for each institution but, like hospital budgets, must be approved by the Prefect and the Minister of Health.

In the private sector the cost of treatment is also fully refunded by the health insurance institutions on the basis of a 'prix de journée', but this 'prix' is calculated in a different manner and is less comprehensive than in the public sector. The 'prix de journée' for non-profit clinics is fixed by the Prefect, and is usually based on the tariffs of the nearest public hospital. In the majority of the for-profit clinics (90%), the 'prix de journée' is fixed at negotiations between the regional 'caisse' of the health insurance organisations and the clinics. The 'caisses' however are themselves bound by government prices and incomes policy, which means that the Minister of the Economy effectively determines the annual increase in the 'prix de journée' for the clinics. Another important difference between the 'prix de journée' in the two sectors is that a number of services provided in the public hospitals, such as fees for the use of operating theatres, blood transfusions and

laboratory tests, are billed separately.

During the fifties and sixties, while the hospital sector as a whole was expanding, there was little conflict between the two sectors, and it could be argued that the private sector played a positive and useful role in the health services of the nation. The finance for the creation of private clinics came from private investors, and the absence of administrative controls and procedures meant that the private sector was able to respond quickly to meet the growing demand for hospital care which the public sector could not satisfy.[21] The changed economic conditions of the seventies, and the successive financial crises of the health insurance organisations, have led to a more critical analysis of the private sector. In the first place the market has proved to be an imperfect regulatory mechanism. Private clinics have not been established in the areas in which they are most needed. The highest concentration of hospital beds can be found in those areas which are already well provided for by public hospitals, and under equipped Regions like the Nord-Pas de Calais have been neglected by the private sector. One response to this situation was the 1970 Hospital Law which introduced a centralised and coordinated system for processing hospital construction programs in both sectors. This policy and its effects will be described in detail in chapter six.

The controls introduced by the 1970 Hospital Law and the increasing financial restrictions imposed on health spending led to the emergence of open conflict and competition between the two sectors. Government policy as stated in the 1970 law, and reiterated by Giscard d'Estaing in one of his rare statements on health policy, was that the private sector, as an integral part of the French health system, would not be

Hospital Bed Population Ratio
as at 1st January 1972

Region	Beds	Ratios
Région parisienne	48100	5,0
Champagne	7200	5,4
Picardie	6500	4,0
Haute-Normandie	7100	4,6
Centre	8700	4,2
Basse-Normandie	6700	5,2
Bourgogne	7700	5,0
Nord	13000	3,4
Lorraine	9900	4,3
Alsace	9300	6,3
Franche-Comté	4800	4,7
Pays de la Loire	11100	4,2
Bretagne	10800	4,3
Poitou-Charentes	5700	3,8
Aquitaine	9500	3,8
Midi-Pyrénées	9700	4,4
Limousin	3200	4,3
Rhône-Alpes	24600	5,3
Auvergne	6500	4,9
Languedoc	7900	4,5
Provence-Côte d'Azur	15500	4,5
Corse	900	4,4
France entière	**234400**	**4,6**

(Source: CREDOC)

discriminated against by government.[22] However, according to R. Gatelmand of the FMF, the effect of government price controls and the new system of authorising new hospitals was stifling the private sector and leading to a 'nationalisation secrète de la médecine'. In support of their case the private clinics argued that they were more efficient than the public hospitals, and that therefore if the government was anxious to reduce the cost of the health service they should be allowed to play a greater role, rather than the opposite.[23] The 'Union Hospitalière Privée', one of two pressure groups representing the private sector, published a full page advertisement in 'Le Monde', setting out the annual increase in the 'prix de journée' in both sectors over a number of years, with a title in large black letters claiming '18 years of discrimination against the private sector'.[24] The 'Fédération Hospitalière de France' (FHF), the professional body of hospital administrators, rejected this claim and argued that on the contrary the private sector enjoyed a considerable advantage over the public sector as a result of their independence and the absence of strict administrative controls.

The basis of the arguments put forward by the private sector to prove their greater efficiency were calculations based on the 'prix de journée'. These calculations involved comparing the cost in each sector for the same medical procedure. Thus in one example the cost of a simple hernia operation in the public and private sector is compared. In the public sector the cost was calculated to be F4,896.58, compared with only F2,302.94 in a private clinic. This and other examples were put forward as clear and dramatic proof of the greater efficiency of the private sector. However, this argument is somewhat spurious given that the basis of these calculations, the 'prix de journée', is determined differently in each sector. The FHF was quick to point out this fact,

and also that the 'prix de journée' in public hospitals is an average tariff that covers all the services provided by the hospital, and hence in no way represents the cost of individual operations. They also pointed out that the public hospital is obliged to stay open twenty-four hours a day and all year round, to provide facilities for medical education, and to accept all patients, whereas the private sector is free to set its own opening hours, has no responsibility for medical training, and is free to choose its own patients. A more rigorous comparison of the costs and activities of the two sectors has been carried out by a team of researchers under E. Levy. This survey supports to a certain extent the arguments of the FHF. Significantly, Levy found that within both sectors the cost of the same procedures varied considerably between institutions. Thus he argued that 'it is impossible to say whether the one sector is more efficient than the other'.[26]

Levy also found evidence to support this argument that the private sector 'creams off' the most profitable cases, and that the public sector is left with the most complicated and expensive cases. Levy found that the activity of the clinic is characterised by what he calls a 'mécanisme sélectif', which ensures a high level of acts in 'K' with average coefficients, or in other words a high percentage of routine surgical operations like appendectomies.[27]

Official government policy for most of the seventies was that the private hospital sector formed an essential part of the national health system, and that both sectors should receive equal treatment. In the past, impartiality has tended to mean leaving the private sector to its own devices, and up until recently this has suited it well. But the government is now committed to reducing health spending and this implies

the regulation of both public and private hospital sectors. When resources are scarce, an advantage gained by one sector is seen by the other as a loss. Both the public and private sectors are represented by well organised pressure groups quick to analyse and denounce any government which affects their respective positions. In this situation policy is not what government ministers say their intentions are, but rather what the pressure groups interpret them to be. Further confusion is added by the fact that the responsibility for implementing health policy is divided between the Administration and the social security organisations. The Administration, according to a senior civil servant in the Ministry of Health, is as a matter of principle hostile to anything associated with 'lucre', and by instinct favours the public sector. The social security institutions in contrast are dominated by a financial logic. Their main goal is to balance their books. The predominant role in this organisation of the employers' union, the 'Confédération Nationale du Patronat Français' (CNPF), reinforces this logic. The private clinics 'cost' the health insurance institutions less, hence they tend to be more sympathetic to the claims of this sector according to an ex-director of the CNAMTS.

The representatives of the public sector hospitals claim that they have borne the brunt of the government's economy measures, while the private sector has been left virtually untouched. The private sector claim that the strict control of the annual increases in the 'prix de journée' has starved them of resources, and suggest that the government is attempting to abolish the private clinics by stealth. The government continues to claim that their intention is to treat the two sectors equally. Not surprisingly, an independent analyst has described policy during this period, in the sense of what governments have actually done, as

contradictory. The system of the 'prix de journée' as a method of financing hospitals has itself been a policy problem that the Ministry of Health has been grappling with for a number of years. In recent years it has been widely argued that this system of funding hospital care is inflationary and discourages cost conscious management.[28]

As the 'prix de journée' is a global tariff which does not distinguish between different services provided in a hospital, it makes it difficult to evaluate the cost and efficacity of different procedures. The 'prix de journée' makes it logical for hospital administrators seeking to maximise the income of their establishments to keep patients in hospital longer than necessary, and to hospitalise as many mildly ill patients as possible. Furthermore it has been claimed that the system discourages hospital administrators from making the maximum use of their out patient departments, which in absolute terms are cheaper, but which are refunded at a lower level by the Health Insurance Funds, and hence result in a lower income for the hospital. In 1970 two alternative forms of hospital-tariffication were proposed, which have since been experimented with in a number of selected hospitals. However, by 1981 there were still no signs that the government was prepared to introduce either of these new systems, and so the experiments continue.

In fact the issue of the 'prix de journée' may well be a false problem. The statistics produced by the Ministry of Health show that despite the fact that the overall number of patients treated in the public hospitals has been increasing steadily, the average length of hospital stay of those patients has been declining, and is now almost identical to the average length of stay in the private sector where financial incentives dictate that this should be kept to a minimum.[29] Thus it seems that

hospital administrators consider more than just the short term financial interests of their establishments, and that a commitment to public service can produce equally good results as a commitment to profit. According to a 'Conseiller d'Etat' with specialist knowledge of the 'prix de journée' system, the faults of the existing system have been exaggerated, and that even if the proposed reforms were to be introduced the problem of rising hospital costs would remain. His view is that while some aspects of the problem might be solved, new ones would be created, and he thus argues 'better the devil you know...'

The crux of this relationship is the extent to which the former should be able to limit the freedom of the latter in the attempt to control escalating hospital spending. As in the case of general medicine, demand for hospital care is largely determined by the supply of hospital beds, and the budget of a hospital by the decisions taken by individual doctors as to whether to hospitalise a patient and what treatment to prescribe. The 'Sécurité Sociale' does have a corps of medical inspectors whose task is to visit hospitals to verify the appropriateness and necessity of treatment being provided. However, these inspectors tend to be young doctors who have failed to make the grade in hospital medicine, and who are hardly in a position to question the judgement of a 'Grand Patron'. Thus the main burden of responsibility for controlling hospital costs falls with the hospital administrator.

This traditional structure has remained largely unchanged. The hospital director of today is responsible for the day-to-day administration of the institution and has little authority over the 'chef de service'. The 'chef de service' remains independent of the hospital administrator and has no financial responsibilities. Within the hospital there is what

Steudler describes as a 'double hiérarchie d'autorité', in which power is divided between the administrators and the medical profession. Steudler argues that although the organisation of the hospital in many ways corresponds with the Crozierian model of bureaucratic organisations (parallel hierarchy, formalised and informal rules, fear of face to face relations), it is distinguished by the specific function of the hospital, the nature of medical care, and the role of the medical profession.[30] Thus, according to Steudler:

> Le corps médical est une profession puissante, organisée, bénéficiant d'un pouvoir charismatique fort, détenant une compétence technique, qui oppose aux exigences de l'administration la défense du malade, l'urgence médicale, et défend avec jalousie ses privilèges.[31]

Steudler's conclusion that the profession is a cohesive and homogeneous entity may be a shade simplistic. Although social and educational backgrounds may be similar, like the higher civil servants studied by Suleimann, the interests of the medical profession are probably influenced to an important extent by the role they play within the system. In fact only a small proportion of hospital doctors are 'chef de service', and by no means all the doctors working long and unsociable hours can look forward to enjoying the same privileges as their superiors. In addition there is a considerable amount of conflict between differing medical specialities, especially where those specialities are closely related.

Nevertheless, the traditional separation of responsibilities and the service based structure of the hospital has complicated the process of introducing a mechanism to control spending on service. This is well illustrated by a quote from a hospital doctor interviewed by Steudler:

> Au semestre dernier le patron savait qu'il avait cent trente sept malades, mais il n'avait aucune idée de ce qu'il avait dépensé. Si vous demandez au chef de service le prix d'un électrophorèse, d'une artériographie, il ne le sait pas. On a une vague notion du prix de journée, mais on est souvent un chiffre en retard.[32]

The medical administrative arguments for reforming the existing hospital structure and replacing it with a departmental based hospital organisation were put succinctly by the working group for health policy of the VIIIth Plan. In the first place they argued that the advances in modern medicine have led to the increasing interdependence of medical specialities which require a greater degree of coordination of equipment, personnel, and medical activity. This coordination, as well as a system of quality control and evaluation of medical techniques, presupposes that hospitals are organised around larger departments.[33] Tentative steps towards implementing such a reform have been taken in a few selected hospitals, supposedly as a trial run, but as yet there is no sign that a general reorganisation of hospital administration will be implemented.

In conclusion it can be said that the hospital sector, both public and private, has borne the brunt of government attempts to reduce health spending, partly because its is over the hospital sector that the government has the most control, but also because hospital costs represent the largest single item of the health budget. The apparent lack of success of these efforts is illustrated by the statistics on health spending during the 1970's when annual increases in hospital spending regularly exceeded inflation. In 1981 economy measures had some effect and the increase was held down to just over 17%, but the predicted

increase for 1982 has shot up once again, to over 20%. The dominant pattern is one of steadily increasing expenditure. The problem continues, and is likely to continue for some time yet, to challenge the ingenuity of policy makers, whether they be of a socialist government, or the old 'majority'.

5.vi. **Controlling Demand**

Given the failure of government policies to control the supply of health care, why haven't policy makers attempted to control demand? The main explanation is that the only way of influencing demand is by raising the price of health care, and this would conflict with the principles of the 'Sécurité Sociale', as well as reversing the policy of extending health insurance coverage to the whole population just as that objective has been finally achieved. Nevertheless some tentative steps were taken in this direction. In an attempt to discourage unnecessary spending on drugs, the then Minister of Health, Simone Veil, reduced the rate from 70% to 30% at which certain products, called luxury drugs, were refunded. The 'ticket modérateur' on all drugs, or the proportion of costs borne by the consumer was also slightly increased. However, the efficacity of these measures is debateable. A small proportion of the population (10%) are responsible for 70% of the nation's health spending, and the demand of this 10% is inelastic. Any increase in the cost of health care to the consumer may therefore be counter-productive.

In another attempt to influence demand the government of Raymond Barre attempted to increase the proportion of health costs borne directly by the individual by reviving the 'Ticket Modérateur d'Ordre Public' (TMOP) which had been introduced by 'Ordonnance' in 1967 but never

implemented. The TMOP limited the extent to which 'mutuelles' could cover their members' medical expenses to 95% of the total cost. This measure was strongly opposed, not only by the 'Fédération Nationale de la Mutualité Française' (FNMF), the unions, and the parties of the left, but also by Jacques Chirac and the RPR. The FNMF mounted a campaign against this policy, which included organising the sending of seven million letters to the Elysée.[34] Faced with this show of opposition, and with Presidential elections not far off, the Minister of Health was forced to make a strategic withdrawal. The decree was repealed, and as a substitute a special fund to encourage preventive medicine, jointly financed by the Ministry of Health and the FNMF, was created.

The failure of these cost control policies has resulted in the continuing periodic 'crises' of the health insurance organisations. The creators of the 'Sécurité Sociale' had intended to create an independent organisation which would be self-financing. Although that independence has become increasingly mythical, the organisation still has the duty to balance its budget. The organisation is financed by deductions at source from wages, and employers' contributions. However, ever since its creation, and especially since the fragmentation of the original 'caisse unique', it has found this task more and more difficult to achieve. During the seventies structural factors added to this difficulty. The unofficial incomes policy followed by the government of Raymond Barre meant that wage increases were kept below the rate of inflation.[35] As a result the rate of increase of the available resources of the Health Insurance Funds was below that of the rate of inflation. At the same time spending was increasing at or above the level of inflation. Rising unemployment has further reduced the resources of the 'caisse'. It has been calculated that an increase of 100,000 in the level of

unemployment leads to a loss of income of FF1.5 billion for the insurance funds.[36]

The Government's response to these crises was a series of 'plans de sauvetage' which have generally involved raising the level of contributions. In 1975 the 'plan Durafour' raised contributions to the insurance funds by 1.5 points to raise FF7 billion. In September 1976 the 'plan Barre' raised another FF6 billion by increasing contributions another 1.40 points. The 'plan Veil' raised the ceiling of contributions by four points, and later five points, to produce FF11 billion. Finally, in July 1979, the 'plan Barrot' introduced a 'cotisation spéciale' of one point to balance the books of the 'caisse' for that year. This cotisation was described as temporary, to be cancelled once the necessary savings in the health services had been achieved. This extra contribution was in effect cancelled a few months before the Presidential elections, but was reintroduced almost immediately by the new Socialist Government.

However, the policy of increasing contributions can be no more than a stop gap measure which fails to tackle the fundamental problem of rising health costs. It has the added disadvantage of being politically unpopular, as it is opposed by a powerful alliance of forces. Trade Unions were understandably hostile to a measure that effectively reduced their members' take-home pay. Those in the higher income bracket opposed for similar reasons any attempt at raising the ceilings on contributions. Employers and the Ministry of Industry were in their turn against increases in employers' contributions which result in increased wage costs and hence fuel inflation and affect international competitivity. Finally these increases in contributions to the Health Insurance Funds were also embarrassing for President Giscard d'Estaing

and his liberal followers as they pushed the rate of social transfers from 36.3% to 42% of GDP. In 'La Démocratie Française' Giscard d'Estaing, referring to the level of direct taxation and other mandatory contributions which at that time stood at 35%, suggested that if this increased any further it would represent a serious threat to individual liberty and a fundamental change in the nature of French society.[37]

5.vi. **Conclusion**

The major problem facing policy makers in the field of health in France has shifted over time, as it has in most industrial countries. The issue of equality is no longer a major concern. This is partly due to the fact that, as Wildavlsky has argued, equal health is an illusory objective, and that the objective of policy makers has always been to provide equal access to care, rather than equal health.[38] Despite the continuing existence of inequalities in health, the objective of equal access to health care has to a large extent been achieved. In 1977 health insurance coverage was extended to include priests and prostitutes (sic), significant professional groups that still remained outside the system. Close on 100% of the population of France are now covered by comprehensive health insurance. But the main reason for the decline in salience of this issue is that it has been overshadowed by another - the issue of the rising cost of health care to the nation.

The response to the problem of controlling escalating health costs has been a variety of measures aimed at influencing the supply and demand for health care. However, as Maynard and others have argued, the health market differs from the classical market in that demand is determined by supply, which in the context of the French health system means that the size of the health budget is to a large extent determined

by the innumerable and isolated decisions of individual doctors.[39] Policy initiatives have thus been centred on the public hospital sector where the degree of central government control is the greatest, but even so is far from total.

The problem of the financial situation of the health insurance organisations, linked to but not the same as the problem of escalating health costs, has existed since the creation of the system, and has been met by incremental reforms. This policy problem is largely a result of the particular form taken by this system which makes it especially sensitive to general economic conditions, and not to any factors that can be attributed as being peculiar to the health policy domain.

PART THREE

THE CASE STUDIES

Chapter Six

'LA POLITIQUE CONVENTIONNELLE' - CONFLICT AND COMPROMISE

6.i. Introduction

In part two I have described the history and development of the ideas and institutions that influenced the organisation of the French health system. I have also given a broad description of some of the major issues facing decision makers and briefly outlined the type of policies that have been adopted in response to these problems. In part three I will deal in more detail with two specific policies, 'Les Conventions Nationales' and the 1970 Hospital Law and their implementation. The theoretical justification of this selection is discussed fully in chapter three. Broadly speaking these specific policy case studies have been chosen firstly because they enable us to cover a large part of the French health system, and secondly to contrast different types of policy making.

The 'Convention Nationale' is the agreement between the representatives of the medical profession and the health insurance funds on medical tariffs. This agreement is renegotiated every five years, and is therefore a crucial factor in determining the overall cost of the health system. Earlier I have argued that there is no overall governmment control of health policy and that a number of separate and nominally independent institutions combine or compete in performing this function. In this chapter I intend to show that the 'Convention Nationale' is one of the major policy making tools of government. In chapter five, where the implications of this policy are considered, I argue that although the conventions are in theory limited to determining the price of doctors' services, this system has significant implications for the type of health

care available to the consumer.

Whereas the 'Convention Nationale' is an example of indirect policy making, the 1970 Hospital Law is an example of explicit policy making. Here the decision makers clearly identify a policy problem and their objectives. The policy is formalised by the passing of a law in parliament, and its implementation can be followed step by step by way of the official circulars implementing the policy. Given the differences in the nature of these policies it would seem reasonable to assume that the process of policy making and implementation in each are different.

The two case studies may therefore be justified on the grounds that they permit an analysis of the two major ingredients of any health system, primary health care, and the hospital sector, as well as on the grounds that they allow the analysis of two contrasting 'types' of policy. In so doing, they allow us to test the hypothesis that, not only does the policy making process differ from policy area to policy area, but that it also differs within the same policy area according to the nature of the issue involved.

6.ii. **The 'Conventions Nationales'**

Earlier I have described the development of the French system of National Health Insurance up until the introduction of departmental conventions in 1960. As I have argued, this national insurance system was imposed by central government despite the opposition of the medical profession and was only possible under the special conditions existing at the time. The aims of this new system were both economic and social. Firstly it was, as it turned out, correctly assumed that a majority of doctors would in time come round to sign the new departmental tariff

agreements and that, as a result, medical fees would be codified and harmonised, which would allow the insurance funds to cover a fixed portion of medical costs. This in turn meant that the financial barriers and hence the inequality of access to health care would be removed. Secondly it was hoped that this codification would enable the insurance funds to calculate accurately the annual cost of primary health care, and so to set their insurance premiums at a level which would ensure a balanced budget, thus obviating the need for government financial support. This second objective has been more problematical. The departmental conventions were based on a model agreement drawn up by the Minister of Health. This agreement served as a guide for negotiations in each Department between the local Health Insurance Funds and the local branches of the medical unions. In the event that the medical unions refused to negotiate, the Insurance Funds were authorised to sign agreements with individual doctors. To encourage members of the profession to cooperate, doctors were offered various tax incentives and free coverage from the health insurance organisations for themselves and their families. In addition, doctors who refused to sign the departmental conventions were penalised indirectly through their patients who only received 25% of the normal health insurance refund, whatever their doctor charged.

This blend of the carrot and the stick persuaded the majority of the medical profession to sign a tariff agreement either individually or through the intermediary of one of the medical unions. This tariff agreement in turn went a long way to enabling the government to meet one of the primary objectives of the founders of the 'Sécurité Sociale'. It guaranteed the consumer the refund of a major part of his medical costs. However, the system was not totally satisfactory. Despite the

fact that each departmental convention was based on a model drawn up by the Ministry of Health, the precise details of each agreement were determined by the result of local negotiations between the Health Insurance Funds and the medical profession. As the departmental 'caisse' still enjoyed a considerable degree of independence from the central insurance fund, there was still no effective control of the price of health care. This lack of control was particularly important with relation to the issue of the 'droit au dépassement'. The model contract on the basis of which local tariff agreements were negotiated allowed exceptions to be made of doctors who were either highly qualified or experienced. These doctors were allowed to charge over the normal rate and their patients refunded accordingly. Although guidelines were set down as to how these exceptions should be allocated, it was up to the local fund to take the final decision. The way in which these decisions were made varied from department to department and so the ability of the insurance fund to control the evaluation of the cost of health care diminished.

Another problem that emerged was that although the majority of doctors came to accept the system, there were some important exceptions. In Paris intra-muros, the Rhône-Alpes Region and the Côte d'Azur, the strongholds of the newly formed 'Fédération des Médecins Français' (FMF), the majority of doctors refused to sign a tariff agreement. Specialists throughout the country also proved more resistant to the combination of threats and blandishments made by the government.

These exceptions affected both the extent to which the insurance organisations catered equally for the whole population, but also reduced their ability to control the health spending budget. Although the departmental conventions gave the Funds the power to determine the

costs of doctors' services, it did not give it the means to control the volume of medical activity. Thus, throughout the sixties, the government was periodically called upon to intervene to balance the budget of the health insurance organisations. The concept of a system of national conventions was a reaction to this situation.

The idea of a national tariff agreement was in fact first proposed by docteur Monier, the president of the 'Confédération des Syndicats de Médecins Français' (CMF), in reaction to a report from the working group on health policy of the VIth Plan. This report criticised the system of fee for service payment, identifying it as being at the root of the financial difficulties of the Health Insurance Funds and suggesting a number of possible alternatives. Seeing this as an early warning of new government policies likely to threaten the fundamental principles of 'la médecine libérale', Monier hoped that by pre-empting the government with his own proposals, which included a number of the suggestions put forward by the plan, he would prevent the more drastic and restrictive reforms of the health service which he feared possible.[1] However, another possible interpretation of Monier's initiative is that the national executive of the CSMF was anxious to regain control over the local branches of the union to which the system of departmental conventions had given considerable importance at the same time as making the national office almost superfluous.

The aim of a 'national convention' was to build on the general acceptance of the system of tariff agreements that had been developed in the sixties. A national tariff agreement was seen as desirable as it would harmonise doctors' fees and allow the insurance funds greater control over the cost of health care by reducing or controlling the number

of exceptions made to the rule.

The political conditions of the day provided fertile ground for the development of this idea. Pompidou's first Prime Minister, Jacques Chaban-Delmas, had just launched his ambitious programme called 'La Nouvelle Societé', through which he hoped to liberalise French society. The basic philosophy behind this 'plan' was to attempt to replace the system of government based on conflict by a consultative system. An essential ingredient for such a system is the existence of trade unions and pressure groups willing to play a constructive part in the policy making process. Dr Monier's initiative in suggesting a national convention fitted this bill ideally as it represented a positive and constructive contribution to policy making, rather than the traditional negative or maximalist demands, and was thus welcomed by the government of the day.

Despite the auspicious start, the negotiation of a detailed agreement between the Health Insurance Funds and the medical profession took over a year. The issue of 'la médecine libérale' and the medical profession's fear that the government would attempt to phase out liberal medicine by stealth was one of their major concerns. To allay this fear the 'Conseil des Ministres' issued a formal statement declaring that the government fully supported the principles of 'la médecine libérale'[2], and a motion to a similar effect was passed by the National Assembly.[3] After lengthy negotiations, and comforted by the above guarantees, the CSMF felt able to sign the first National Convention on 28th October 1971.[4]

The agreement that was signed between the medical profession and the Health Insurance Funds was for a period of five years, renegotiable.

It covers two main issues. Firstly it determined the value of the 'key' letters. As outlined earlier, these key letters represent the different activities of the medical profession, with varying degrees of precision. The values of these letters are renegotiated annually at what is called the 'avenant tarifaire' to take account of inflation. The second main feature of the 'Convention Nationale' is that it set out the contractual relations between the medical profession and the insurance funds. These ranged from procedures for the mediation of disputes between doctors and health funds to the administrative procedures required of doctors by the insurance funds. The most important new element in this relationship introduced at this time were the 'Tableaux Statistiques de l'Activité des Pratitiens' (TSAP). The TSAP were based on the collated statistics of all doctors' medical activity in a given region, and were designed to serve as a tool for identifying abnormal prescribing practices and activity. The responsibility for warning and disciplining transgressors was given to a committee dominated by local doctors.

The introduction of the TSAP represented a major concession on the part of the medical profession, for while it did not limit the right of doctors to prescribe as they saw fit, it placed the profession under what J.J. Dupeyroux described as 'en liberté surveillée'.[5]

As well as the guarantees from Government mentioned above and certain tax concessions, the medical profession also received a guarantee from the Health Insurance Funds that they would bring to an end their policy of promoting health centres and that in future no third party payment agreements would be authorised without prior consultation with local doctors who would have the right of veto.*

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* Article 18 of the 'Convention Nationale entre la Sécurité Sociale et le Corps Medical'

Despite the good intentions manifested by all involved, the negotiation of the first National Convention proved a difficult task. When the text of the agreement was published, the differences between the negotiating parties were clearly evident. Rather than a joint statement, each of the two parties issued statements of their own, declaring their overall agreement but clearly indicating their different priorities, interpretations and reservations. In the declaration drafted by the CSMF, the representatives of the medical profession state that the principles of 'la médecine libérale doivent demeurer en France un des fondements du système de santé'. In contrast, in the statement issued by the Health Insurance Funds, it is simply 'noted' that the majority of the French people wished to maintain the system of liberal medicine. The medical profession accepted that the collective negotiation of tariffs is not incompatible with the principles of liberal medicine, 'à condition que la valeur des actes médicaux conserve son rang dans la hiérarchie des services'. The Health Insurance Funds in their turn accepted the principles of liberal medicine on condition that 'celle-ci ne soit pas détournée de son but au détriment de l'efficacité des nécessaires contrôles qu'entraînent les libertés reconnues au monde médical'. The representatives of the medical profession stated their opinion that the escalation of medical costs was linked to scientific progress and, as such, 'ces dépenses constituent une des meilleures finalités humaines et sociales de l'expansion économique'. The Insurance Funds in contrast called on the medical profession to fully assume their economic and financial responsibilities, and warned that only if they did so would the system of liberal practice combined with the collective finance of health care be able to survive.

Despite the fact that both the government and parliament had committed themselves to maintain 'la médecine libérale', some important

sections of the profession remained opposed to the 'Convention'. The FMF boycotted the negotiations throughout, although they signed the agreement at the last moment to ensure their representation at the annual 'avenant tarifaire', and on the various national and departmental committees set up to deal with conflicts between the parties to the agreement. The 'Ordre National des Médecins' made its opposition clear. At the time its president, professor J.L. Lortat-Jacob, was criticised in the National Assembly for exceeding his functions when he denounced the agreement. He argued that as the terms of the convention conflicted with professional ethics, and as the role of the 'Ordre' was to defend those ethics, his action was perfectly legitimate.[6] Lortat-Jacob himself refused to participate in tariff agreement.

The Labour unions, the CFDT and the CGT, were also initially opposed to the 'Convention Nationale'. They felt that it would result in increased control of the medical profession by the employers and government. The attitude of doctors was ambivalent; they were not unappreciative of the various advantages accruing from the agreement, but they were suspicious of the system of 'profils médicaux' introduced with the TSAP, and feared that the yearly negotiations of tariffs would be dominated by the Minister of Finance.

Nevertheless, the statistics show that the vast majority of the profession accepted the system of the National Convention. By 1973, only 2,020 doctors, or 3.95% of the profession, had opted to remain outside the tariff agreement.[7]

The yearly negotiations of tariffs proved difficult but never reached the point of complete breakdown. If the profession had felt in any

way that they had been tricked into signing the agreement, a perfect opportunity to withdraw was provided by the ruling of the 'Conseil d'Etat' on a case brought by the FMF which effectively rendered the 'Convention' null and void on the basis of a legal error. A temporary arrangement however was quickly signed to cover the remaining life of the convention. In this new wording the requirement of the Health Insurance Funds to negotiate with 'les organisations représentatives de la profession' was replaced by the requirement to negotiate with 'une des organisations représentatives de la profession' (my emphasis); a change that very soon proved to be of great significance.

The spirit of compromise and cooperation that led to a proposal for a national agreement was severely strained by the process of negotiating that agreement. Relations between the parties involved were strained even further by the events that followed the signature of the convention. Firstly the Insurance Fund allowed the FMF to sign the convention, despite the fact that it had boycotted all the earlier discussions, and without the prior consultation of the CSMF. Secondly the yearly renegotiation of tariff levels proved fertile ground for conflict.

By the time the second convention came round for negotiation, Jacques Chaban-Delmas had been replaced, and his 'Nouvelle Société' programme had been forgotten. Valery Giscard d'Estaing had replaced Pompidou as President, and his second government, led by Raymond Barre, was in office. The atmosphere and conditions surrounding these negotiations were thus very different from the context of the first.

The second 'Convention Nationale' was signed on 3rd February 1976.[8] This time the tables were turned and it was the FMF that played the

leading role in the negotiations with the CSMF, withholding its agreement until the last moment and then, like the FMF, adding its signature at the last moment to ensure a place on the various consultative committees. The amended version of the text, setting out the statutory requirements of the Insurance Funds which resulted from the ruling of the 'Conseil d'Etat' over the first convention, referred to above, meant that the insurance funds could effectively ignore the representatives of the majority of the medical profession and still expect to agree a national convention which would apply to the whole profession.

In fact the new agreement differed little from the first, and the main reason for the hostility of the CSMF was their disaffection with the system built up over five years of annual negotiations over tariffs. Throughout the period of the second convention this was again to be a major source of conflict, with the CSMF becoming increasingly militant in its protests against government policy. This militancy culminated in the street protests and strikes organised by the CSMF in 1979 and 1980.[9]

The third 'Convention Nationale' was signed on 28 May 1980.[11] Again the FMF was the main actor in the negotiating process, but this time the opposition of the CSMF was such that they refused to add their signature to the agreement even at the last moment. The total rejection by the CSMF of the new agreement was a result of two important innovations that were introduced with the third convention, both of which were regarded as completely unacceptable. The first of these was the creation of what was called the 'secteur libre'. Doctors who opted for the 'secteur libre' were allowed to charge their patients as they saw fit. The Health Insurance Funds refunded the medical costs of consumers treated by these doctors at 75% of the agreed tariff for

consultations, and not at the previous penalty rate of 25%. The second innovation was the introduction of the concept of the 'enveloppe globale'. This linked the rate of annual increase of doctors' honoraria to the rate at which primary health care costs had increased over the year, the two rates being inversely related. Ironically the union that had been initially created to defend the principles of liberal medicine and to combat the socialisation of health care was now acting as the defender of a form of socialised medicine against what it interpreted as a government attempt to set the clock back to the days of unfettered liberalism.

The 'Conventions Nationales' have thus been major stages in the development of primary health care policy in France in the seventies, and from the first to the last the involvement of governmental actors has been crucial, if not always evident. Initially the declarations made by the Council of Ministers and the National Assembly before the signing of the first convention, effectively consecrated the existing organisation of primary health care as official government policy. Thus from the start the 'Conventions Nationales' were more than simple tariff agreements between an independent health insurance fund and the medical profession, but also an element of government health policy. The combination of the private independent practitioner with a collective system of financing health care, is therefore not just an accident of history, but the result of a conscious policy decision. Government policy for primary health care over the next decade became government policy for the 'Conventions Nationales'. The evolution of this policy can be seen in the changes introduced in each convention. The form and nature of these policies and their evolution can only be understood by examining the role and position of the different actors involved in the almost continual negotiating process that is the system of 'Conventions Nationales'.

6.iii. **The Actors in the Policy Making Process**

Students of the French administrative system tend to stress the symmetry of the French State, and by implication the similarity of the policy making process in different fields.[11] However, while the French administrative system may be highly structured and based on a clearly identifiable model, not all policy making can be explained simply in terms of administrative organisation and procedures. The health system is a case in point where what happens outside the formal administrative structures may be more important to understanding the policy process than what happens within the official bodies. The social security system is a parapublic organisation but, as explained in the previous chapter, it is based on a model and inspired by a philosophy which differs from the Napoleonic tradition. Despite the fact that a number of important changes to the system have been introduced since its creation and the period we are concerned with, it is still clearly very different from the traditional administration, and although the boundaries have been blurred somewhat, it is still a separate and independent institution.

As explained above, the 'Conventions Nationales' are basically tariff agreements. In other words two main actors are involved, the medical profession and the Health Insurance Funds. However, the medical profession as we have seen is represented by two unions as well as by the 'Ordre des Médecins'. On top of the essentially political divisions between the two medical unions are the professional rivalries that exist within medicine in France as in any country.

The health insurance organisations are in their turn made up of three distinct groups. The first of these is the labour unions. In this chapter we will concentrate on the largest of these, the CGT, and the CFDT,

although a number of other smaller unions are also present on the administrative councils of the insurance funds. The second clearly identifiable group is the 'Confédération Nationale du Patronat Français' (CNPF), representing the interests of the employers. Thirdly there are the professional administrators of the fund itself. In the thirty-seven years of its existence 'Sécurité Sociale' has acquired an identity and a momentum of its own. As it has grown to become the pivot of the health system, and as the volume of the funds administered by the system has grown, so the importance of the institution and the personnel employed by it has increased. But here again a distinction must be drawn between those administrators who spend their career within the Health Insurance Funds, and those that are appointed by government to the top positions within the organisation to perform specific tasks.

The final and possibly the most important actor in the process is the government itself. The extent of involvement of government actors is less clear cut, but again we can break this category down into three separate subgroups. The Minister of Health and the civil servants in this department are clearly the ones most closely involved with the Health Insurance Funds. Given the responsibilities conferred on the Prime Minister by the constitution, it would be reasonable to expect a certain degree of involvement from this quarter. The extent of Presidential involvement in the field of health policy, on the basis of the constitution and the existing literature on constitutional practice, might safely be assumed to be minimal. In the following paragraphs I will analyse the role of each of the above groups in the process of policy making with regard to the 'Conventions Nationales'.

6.iv. **The Medical Profession**

The medical profession is the most highly 'unionised' in France. Over 60% of doctors are members of one or other of the two medical unions, a much higher proportion of unionisation than is found amongst skilled or unskilled labour.[12] However, the strength of medical unions suggested by this figure is misleading. Firstly, two competing unions exist, and secondly, each of these is made up of a conglomerate of more or less independent associations representing a wide variety of different and often conflicting interests within the profession. Some individual doctors, and certain associations, are members of both the national federations at the same time.

The CSMF is the largest of the two representative organisations, claiming a membership of 25,000 doctors. The CSMF has a complicated structure of departmental branches as well as separate branches at the national and departmental level for the different medical specialities. Thus within the CSMF one finds the 'Fédération des Omnipraticiens Français', which represents the interests of general practitioners, but also the 'Société de Médecine Générale', a newly created group close to the Socialist Party, which also claims to represent the general practitioner. The 'Union des Médecins Spécialistes Confédérés' claims to represent the interests of different medical disciplines. Other constituent groups of the CSMF are the 'Syndicat National des Médecins de Groupe', representing doctors working in group practices, and the 'Union Confédérale des Médecins Salariés', the small number of salaried doctors. This short list of some of the different component parts of the CSMF gives an idea of the conflicting interests which have to be reconciled by its leaders. It is clear that the interests of specialists and generalists practicing 'la médecine libérale' differ from those in group practice,

and that both have little in common with salaried doctors. Stephan describes the medical profession as 'unie dans l'éthique abstraite, mais divisée dans les intérêts matériels concrets', and gives this as the main reason for their weakness.[13]

Throughout the seventies the CSMF was led by Dr Monier, who took over the presidency in 1960 at the time of the split that occurred over the issue of the departmental conventions imposed by the government. At the time Monier had persuaded the majority of the profession to accept the new system. Monier believed that while the medical profession should remain independent it had to recognise that as the cost of health care became socialised, so the profession would have to be prepared to negotiate with the government and the new institutions created for the financing of health care.[14] This might seem a small compromise, but it marked a new approach for a union that had previously been firmly opposed to any such cooperation with government Health Insurance Funds. In return for this concession the profession received benefits in kind from the government and the Health Insurance Funds after the signing of the first 'Convention Nationale'. On the other hand the agreement placed certain obligations on the profession. The new responsibilities included acceptance of the new system of 'profils médicaux', and meeting the administrative requirements of the Health Insurance Funds. Monier believed that the information provided by the TSAP would show that increases in health costs were due mainly to technical and social factors and not the profligacy of the medical profession. In an internal policy document Monier argued this point and concluded that the TSAP posed no threat to the liberty of prescription of the medical profession.[15]

The signing of the National Convention by the CSMF was thus to

a great extent a result of Monier's leadership. His awareness of the changing nature of medicine, and of the need for the medical profession to take its collective head out of the sand and negotiate with government and the Health Insurance Funds was the first ingredient for a national tariff agreement. The second ingredient which made the agreement possible was the changed political environment represented by the policy of the new Chaban-Delmas government for 'concertation'.

Although the CSMF played an essential role in ensuring that the first national convention was signed, since then its relations with Insurance Funds have steadily deteriorated as I have described above. What was the basis of their growing opposition to the health insurance organisations, and how can the evolution of the CSMF from a strong supporter of the system of 'conventions' to a committed opposition be explained?

Initially the main issue of contention was the evolution of doctors' fees, but by the time the third convention was negotiated it was the very content of the agreement with which the union was in conflict. At first the CSMF interpreted the deteriorating relations between the government and itself as being the result on the part of the Health Insurance Funds of a 'volonté de mener une politique médico-sociale qui leur soit propre, et relève de leur optique purement financière, confortée par leur autonomie de gestion et par la liberté laissée par la tutelle'[16]

Alternatively the action of the Insurance Funds was seen as a 'tentative de prise de pouvoir'. The decision by the 'caisses' to allow the FMF to sign the first convention despite the fact that their opposition to the principles of the agreement had been made abundantly clear was

taken by the CSMF to mean that the partnership sought by the union and advocated by government was purely one of convenience. At first the CSMF interpreted this shift in policy as being inspired by the CNPF which held a near majority on the council of the insurance funds, and did not blame the government. However, by 1980 when negotiations for the third convention had got under way, the CSMF had changed its position, and accused the government openly of encouraging a return to what it called a 'libéralisme sauvage'.[17] The CSMF had thus evolved from a position in which it sought to become a privileged partner of government to a position from which it could envisage cooperating with the CFDT and, according to one of the executives of the union, enter into a series of detailed policy discussions with members of the Socialist Party, then in opposition.

However, it would not be accurate to claim that the membership of the CSMF as a whole had shifted to the left. The policy of promoting the system of national conventions was largely the work of Dr Monier, as has been argued earlier. The shift of the union towards the opposition was also largely the result of Monier's leadership. While the ultimate aim of opposition to government policy was to improve the lot of the different factions within the union and, while the leadership was more or less successful in doing this, the membership followed, but when it appeared that the aim had been transferred into some abstract political goal, the opposition to Monier grew. The distance between the leadership and the rank and file of the CSMF was clearly demonstrated when close on 99% of the medical profession signed the third convention, with only 7% of these opting for the new 'secteur libre'.[18] The election of the socialist government provided another new element to the situation, and Monier was forced to resign the presidency of the union.

What appears to have happened is that Monier's experience of the system of national 'conventions' had led him to change his mind about the 'inevitability of medical progress' and the benefits of 'la médecine libérale', and to come to accept the need for some form of social control of the medical profession. His unceremonious eviction from the Presidency of the CSMF suggests that in this he had moved too far ahead of his colleagues.

The 'Fédération des Médecins Français' (FMF) claims to have a membership of approximately 13,000. Like the CSMF it has individual members in departmental sections, as well as separate sections for the differing medical specialities. Unlike the CSMF its support is not evenly spread throughout the country. It has branches in about thirty Departments but its strongholds are in the Paris Region, the Department of the Rhône, and the Provence-Côte d'Azur. Amongst the groups that form the FMF is the 'Collège Fédéral des Médecins Généralistes de France', 'Le Collège des Chirurgiens Français', and 'La Fédération Nationale des Praticiens Exerçant dans des Etablisements Privés'. The names of these bodies are already a clear indication of the different nature of the FMF. There are no 'syndicats' here, only 'colleges', and 'federations' of which individual doctors are members as they would be of clubs or learned societies. Indeed, unlike the CSMF, it would be wrong to describe the FMF as a 'union' in the strict sense of the term. However the FMF is a more homogeneous grouping than the CSMF and is clearly situated to the right of the political spectrum.

The FMF presents itself as the defender of the pure version of 'la médecine libérale'. It was created in 1960 as a result of the split caused in the CSMF over the issue of departmental conventions. The FMF was

totally opposed to the system of National Conventions and made this opposition clear by boycotting the first agreement, only to sign at the last moment as a matter of expediency. As R. Gatelmand, the Secretary General of the 'Fédération', described it, 'Le train conventionel était parti. Il restait au FMF à courir sur le quai de la gare pour sauter sur le dernier wagon. The FMF had no illusions about 'concertation'. According to Gatelmand the signature of the convention did not mean that the FMF accepted the terms of the agreement. On the contrary it was a strategic move to enable the FMF to 'lutter de l'intérieur pour atténuer une certaine évolution vers une socialisation accélérée de la médecine'.

However, as I have described above, in both 1976 and 1980 it was the FMF that negotiated and signed the national agreements with the Health Insurance Funds, agreements which the CSMF claimed were designed to destroy liberal medicine. At first it seems odd that the FMF, clearly the most conservative of the two unions, should also be the one to continue with the policy of national tariff agreements with the Health Insurance Funds after having initially been so hostile to the concept. This is especially so when one considers that the government and the Health Insurance Funds were following a clearly stated policy of promoting the general practitioner at the expense of the specialist.

The explanation for this can be found in the membership of the FMF. The FMF represents the élite of the medical profession, and to a lesser degree the urban doctor. Although many specialists can be found in the ranks of the CSMF, they tend to come from small towns, and country areas. The well known specialist with a large urban clientele represented by the FMF was not so much interested in the level of tariffs agreed

with the health insurance organisations, but by his 'droit de dépassement', and the extent and nature of the controls exercised by the Health Insurance Funds over his activities. The large clientele provided by an urban environment ensured the specialist a constant high level of demand and the ability to make a good return on investments in medical equipment. The specialists and general practitioners of the CSMF on the other hand were more likely to be dependent on the set tariffs of the Insurance Funds for the totality of their income, and less able to multiply the number of 'actes' performed in order to increase this income.

We therefore have the somewhat paradoxical situation of, on the one hand, the largest medical union, which represents the full panoply of medical activities, and which is willing to play a constructive part in the policy making process, forced to resort to organising strikes and protests, and to seek links with the labour unions and the Socialist Party. On the other hand one finds a minority union dominated by specialists from a few large towns, which is openly hostile to the system of negotiated tariff agreements, and has the declared aim of impeding the implementation of what it sees as government policy, becoming the privileged negotiating partner of that government, and the Health Insurance Funds.

A senior member of the FMF executive, R. Gatelmand, suggests that one reason for this is that the CSMF includes communist and socialist doctors as members, whereas these are specifically excluded from the FMF. However, the presence of communists and socialists in the ranks of the CSMF seems to be more indicative of the wide spread of interests within that union, rather than an explanation for its drift into opposition. Gatelmand's statement however may be more revealing of the ideology

of the FMF, and this ideology may help explain to some extent its apparent influence. The conservatism of the FMF, its strength in Paris, and the fact that it represents the élite of the medical profession, meant that it was ideally placed to influence the highest level of decision makers in government as well as the leaders of the CNPF. This influence was largely informal, and hence difficult if not impossible to document. However, an illustration of the 'closeness' of the FMF to the centres of power is the fact that Dr Gatelmand, as well as being Secretary General of the FMF, also happened to be the personal doctor of R. Barre, the Prime Minister.

The 1980 convention itself might be interpreted as providing further evidence of the influence of the FMF as it marks a definite return to the pre-convention days, and reflects quite closely the views of the FMF. For example the 'secteur libre' introduced in 1980, which allowed doctors to opt out of the insurance system and charge their patients as they saw fit without being penalised, was clearly in the interest of members of the FMF. Generalists and specialists in Paris and other large towns, FMF strongholds, were most likely to exercise this option. The 'enveloppe globale' which threatened to limit annual tariff increases mainly affected doctors in less affluent areas, or non-FMF supporters. This suggests that the FMF was more successful than the CSMF in persuading government and the Health Insurance Funds to adopt its policy proposals.

The 'Ordre National des Médecins' is not strictly speaking a medical union, nor a pressure group, but its role in the negotiation of the 'Convention Nationale' and its influence on health policy should be discussed here. The 'Ordre' was not directly involved in the negotiations

which led up to the signature of the convention, but as it was consulted at various stages during the process, its role should be analysed. The 'Ordre National des Médecins' was originally created by the Petainist government in 1941. It was dissolved after the liberation, only to be recreated in 1948. In legal terms the 'Ordre' is described as 'un organisme privé chargé de la gestion d'un service public'. Its functions include registering all doctors eligible to practice in France, as well as judging and disciplining those accused of transgressing the laws of medical ethics. To be able to practice in France a doctor must be registered with the 'Ordre' (annual subscription approximately £70 per annum). The 'Ordre' is made up of a national committee with local committees in each Department. The members of the departmental committees are directly elected by the profession in each Department. The National Committee is elected by the members of these departmental committees.

The representivity and the legitimacy of the 'Ordre' have been questioned by some doctors' organisations with the Socialist Party in recent years. The doctors who reject the 'Ordre' claim that it is 'une organisation rétrograde de la profession', and that it permits the 'dénaturation de la fonction medicale par la recherche du profit'.[19] The right of the 'Ordre' to judge and discipline members of the profession in the same way as a court has also been questioned by some doctors.[20]

The conservatism of the 'Ordre' has been illustrated on a number of occasions. When the first convention was signed the 'Ordre' supported the FMF and opposed the tariff agreement with the Health Insurance Funds, arguing that this would breach a number of the principles of 'la médecine libérale'.[21] Later this same conservatism was illustrated

by the long but finally unsuccessful battle waged by the 'Ordre' against Simone Veil's proposals to liberalise the abortion laws in France.

The nature of the 'Ordre' goes some way to explaining this conservatism. Both at the national and the departmental level the officials of the 'Ordre' tend to come from the élite of the profession. According to Stephan, the departmental officials of the 'Ordre' are mainly local 'Notables', specialists and university hospital doctors. He points out that of the five presidents of the 'Ordre', all have been to prestigious university hospitals, all but one were surgeons, and all but one came from Paris.[22] Raymond Villey, the successor to Professor Lortat Jacob, who tactfully resigned after François Mitterand's election as President, comes from the same mould. Although not a Parisian, he is professor of clinical medicine at the University of Caen. He is also a product of the university hospitals of Paris, and is said to represent the conservative wing of the 'Ordre'.[23]

Despite the above it would be an over-simplification to take the conservatism of the 'Ordre' as proof of its undemocratic nature. The 'Ordre' can claim with some justification to be the most representative medical organisation as all doctors are obliged to belong to it. The departmental officials are directly elected and the average national rate of participation in these elections is over 50% of registered doctors. This compares very favourably with participation rates for elections in the labour unions.[24] Elections for the departmental councils of the 'Ordre' tend to be staid affairs. There is no soap-box oratory, and any political infighting that occurs is carried out with a dignity fitting the mandarins of university hospitals.[25] Candidates tend to be co-opted by existing members and hence have similar profiles. In many instances

the departmental officials of the CSMF and the FMF are also departmental officials of the 'Ordre'. There is thus a small group of 'activists' (one might call them 'militants' if this word did not have certain incongruous connotations) who are elected on the basis of their reputation and availability, rather than their opinions. The opposition to the 'Ordre', in spite of the encouragement it has received from the Socialist Party, has not had any success in the elections.

What then is the influence of this institution? In the case of both the examples given above, where the 'Ordre' openly campaigned against government policy, it failed to prevent these policies being adopted, and its opposition to the Convention Nationale was ineffective. The Convention was signed and the vast majority of doctors showed their acceptance of its terms by assuming their new administrative responsibilities and operating within the system. Although a large proportion of the deputies of the government majority, like the 'Ordre', opposed the abortion reform law, the law was nevertheless passed by the Assembly with the help of the votes of opposition members.

This suggests that, despite its representativity, the influence of the 'Ordre' on the content of policy and within the policy process is minimal. However, the two examples mentioned above do not necessarily illustrate what might be considered the norm. The influence of the 'Ordre' is usually unpublicised and discrete. To a great extent its influence is dependent on maintaining this discretion. The open hostility and campaign against the abortion reform and the national convention broke this rule at the same time as it broke the modest mask usually presented by the 'Ordre', and was possibly the result of the failure of the normal channels of influence and communication to produce the

desired ends. The abortion issue was also a special case, as it was championed by the President and passed through parliament despite the opposition of his natural majority. Influence of the 'Ordre', it would seem, is in inverse proportion to the salience of the issue.

At another level the 'Ordre' can be seen as a typical example of the parapublic pressure group to which government delegates power on the basis of the specialised or technical qualifications of the group. The 'Ordre' is consulted as a matter of course by the government on all issues affecting the medical profession. The 'Conseil d'Etat', which advises the government on the legality of proposed laws, and which rules on appeals against decisions of the Administration, also relies heavily on the 'avis' of the 'Ordre' and the 'Académie de Médecine' where health matters are concerned. The government of course is not obliged to follow the 'avis' of the 'Conseil d'Etat' or the 'Ordre' but, according to an official in the Ministry of Health, these 'avis' are usually respected as, in his words, 'l'administration a tout intérêt à éviter le conflit - ça rend la vie difficile'. According to the same source the 'Ordre' is an 'interlocuteur privilégié' of the Administration, which often relies on it to arbitrate between conflicting interests within the medical profession. In other words the Ordre' is a classic example of that type of pressure group identified by Suleiman which is accepted by the Administration as a legitimate representative of the general will and as such has considerable influence. In this light it is possible to reassess the influence of the 'Ordre'. Its main concerns are for the broad issues relating to the organisation of the health system and defence of 'la médecine libérale'. It is able to exert this influence as government regularly seeks its advice. Open and public hostility to a policy is likely to be adopted only as a last resort and probably after it has

exhausted all the normal channels through which it would normally channel its influence.

In this context it should be noted that the 'Ordre des Médecins' and the Académie de Médecine' are both élite organisations based in Paris, with the ability to directly contact and influence the highest level of decsion makers. In general this influence may be constructive and desirable, as Eckstein argues in his study of a similar organisation, the British Medical Association (BMA), but it is not necessarily so. It is also one way in which the medical status quo is preserved by and for the élite of the profession.

An example of this given by an official of the Ministry of Health was that of a proposal to allow dentists to perform certain acts that were previously practiced only by orthodontists. In France, orthodontists are medical surgeons who have specialised in orthodontistry, rather than specialist dentists, and are thus members of the 'Ordre des Médecins' and the 'Académie de Médecine'. When the Ministry of Health consulted these bodies on this proposal, the proposal was vetoed by the 'Académie de Médecine', and the Ministry backed down despite the fact that considerable savings would have resulted from this reform.

Thus the influence of the medical profession persists. But it is a different kind of influence as it is wielded by the élite of the profession based in Paris and not by the profession as a whole. Indeed it may well be argued that it is an influence wielded by a minority of the profession against the interests of the majority, and that this goes some way to explain the sense of desperation which characterised the street protests organised by the CSMF in 1980. If this is the case, the issue

is not so much the power of the medical profession and the explanation the particular nature of health care, but rather the power of élites in society. In this event a broader analysis of society and institutions is more likely to provide a satisfactory explanation of policy than one that concentrates on the specific characteristics of the health issue.

The importance of the role of the 'Ordre' is further illustrated by its continued existence and influence under the new regime. The Socialist government, far from abolishing the 'Ordre' as it had promised, found itself obliged to delegate an important role in the implementation of its ill fated reform of medical training to the 'Ordre'. The project of M.Mitterrand, presidential candidate, seems to have disappeared from the agenda of M.Mitterrand, President.

6.v. **The Health Insurance Funds**

The 'Convention Nationale' was the result of negotiations between the Health Insurance Funds and the medical unions. How these organisations came to exist has been described in chapter two but it is worth restating their most significant features: the uniquely independent status of the Health Insurance Funds within the administrative framework can be traced back to their origins in private mutualist societies set up by trade unions, paternalist employers, or the Church. Despite numerous reforms the Insurance Funds are still quasi-private organisations to which the State delegates the responsibility for financing the health systems of the country. The Insurance Funds are a group of separate organisations collecting contributions from different sections of society. However, the largest fund, the 'Caisse Nationale d'Assurance Maladie des Travailleurs Salariés' (CNAMTS), by far outweighs the smaller funds.

The Insurance Funds are run by a 'Conseil d'Administration' representing the users, and not by civil servants. The funds are financed by contributions deducted directly from wages and employers, and not indirectly by the State. Up until 1967 the 'Conseil d'Administration' was made up of elected representatives of the main labour unions and the representatives of the employers' federation. Since the 1967 reform of the 'Sécurité Sociale', and the introduction of what was called the system of 'l'administration paritaire', the council has been selected by the government from a list of nominees put up by the interested parties. Half of the seats of the new council are reserved for the representatives of the employers, and the remainder shared between the different labour unions according to their representativity. For example, the administrative council of a typical 'caisse primaire', the basic unit of the administrative structure of the 'Sécurité Sociale', is made up of nine representatives of the employers' federation, three from the CGT, two from 'Force Ouvrière', two from the CFDT and one each from the CFTC and the CGC. This new method of allocating seats on the 'Conseil d'Administration' of the Health Insurance Funds shifted the balance of power away from the labour unions who opposed government health policy to the CNPF and their allies, who were in theory more likely to support it.

It is the administrative council of the Health Insurance Funds that is responsible for determining the policy of the 'Sécurité Sociale'. The national conventions were negotiated between the medical profession and the Health Insurance Funds, and not with the Minister of Health or his representatives. It is the Health Insurance Funds that set doctors' tariffs and introduced the system of the TSAP. They effectively manage the bulk of health spending in France and as such must be considered

as crucial actors in the health policy process. How do the various groups that make up the administration of the Health Insurance Funds interact to produce policy?

6.vi. **The Confédération Nationale du Patronat Français**

The major beneficiary of the 1967 reform of the institutions of the 'Sécurité Sociale' was the CNPF which, with 50% of the seats on the new administrative councils, was given the power to control the decisions of the Health Insurance Funds. The reformers hoped that as the employers were the major contributors to the Health Insurance Funds, and as these charges represented a significant proportion of the production costs of industry, this would produce a more responsible approach to the problem of rising health costs. The object of the exercise was to avoid the government having to intervene at regular intervals to sort out the finances of the funds, and to escape the attentions of the competing interest groups. This aim was partially achieved. In 1980 the then Minister of Health was able to refuse to receive a delegation from the CSMF, which wanted to present its objections to the new convention, on the grounds that this was purely the responsibility of the administrators of the Health Insurance Funds. The need for government to intervene regularly to balance the Health Insurance Funds' budget, however, was not avoided. The reasons for this failure were twofold; on the one hand the ambiguous status of the Health Insurance Funds, on the other the ideology of the CNPF.

The introduction of the system of 'administration paritaire' led to the creation of two clear groups within the executive of the Insurance Funds. The majority group was made up of the CNPF and the two minority labour unions. Ranged in the opposition camp were the CGT and the

CFDT. The CNPF was able to rely on almost all issues on the support of 'Force Ouvrière' and the CGC and thus had a guaranteed majority in the administrative council of the 'Sécurité Sociale'. This is reflected in the fact that since 1967 the presidency of the Health Insurance Funds has alternated between the CNPF and 'Force Ouvrière'. The present president is M.Derlin of 'Force Ouvrière', however the presidency is little more than a symbolic title and, according to a spokesman of the employers' federation, the dominant actor is always the CNPF.

In 1979 at the annual conference of the CNPF, M.Yvon Chotard set out the ideas of the employers' federation on the social security institutions. He argued 'Notre systéme de protection sociale ne peut continuer de se gonfler indéfiniment sous l'influence de mécanismes anonymes, irresponsables et incontrôlés'.[26] The main complaint of the CNPF was that the level of their contributions to the health insurance organisation was too high. The CNPF called for an end to the practice of confusing incomes policy and social policy and for the right of parliament to discuss and to fix the level of social spending. To this end the CNPF proposed that the financial link between the health funds and the retirement and family benefit fund be cut, and that the practice of transferring funds from one fund to another cease. Family benefits, they argued, should be financed out of general taxation, and the responsibility for financing the social security should be divided equally between employers and employees. They proposed increasing the powers of control of the Health Insurance Funds over public hospitals, and argued that the consumer should be called upon to finance a greater proportion of his health costs. The CNPF also recommended increased taxation on tobacco* and alcohol

as a means for raising additional finance for the health system. Chotard concluded:

> Les Français doivent prendre conscience du côut économique d'un système dont ils ne percoivent guère que les avantages. Il sera alors possible de se demander si la protection sociale n'a pas depassé son objet et si le moment ne serait pas venu de redonner une place à l'initiative des individus.[27]

The proposals of the CNPF consist of a number of practical measures aimed at simplifying and improving the system, but also, and more importantly, a conclusion that questions the original objectives of the institutions. Thus the solution to the crisis of the social security institutions in the view of the 'patronat' was, in the first place, to clearly separate health spending from spending on social policy objectives and, secondly, to shift the cost of financing the system from the employer to the individual. In so doing they were challenging the basic aims and objectives of the 'Sécurité Sociale' and indicating their preference for a health policy based on entirely different principles.

In approaching the issue of the relationship between the medical profession and the CNPF it would be reasonable to assume that the medical profession and the employers share common interests and similar values, and that hence the CNPF is likely to be sympathetic to the demands of the medical profession. The medical profession have for long been defenders of liberalism and the free market. The CNPF under the presidency of Michel Ceyrac was an equally strong supporter of these principles. Given this identity of opinion one might expect to find that a class analysis of the decision making process would be revealing and useful. However, while this form of analysis might be revealing in the

case of a larger more abstract problem, it does not provide many satisfactory answers in this specific case, where what actually happens conflicts with what might be expected.

The attitude of the CNPF towards the medical profession was in many ways highly critical, and does not show any signs of the existence of class solidarity. In fact the interests of the employers and the profession, during negotiations on the national convention, were diametrically opposed. The primary objectives of the representatives of the CNPF were to limit the level of contributions paid by industry to support the health system. To do this they sought to restrain the overall costs of the health system, which in turn involved attempting to limit doctors' fees and to control the level of health activity. In private the CNPF argued that the medical profession shared some of the blame for the acceleration in the cost of health care in France in recent years. A spokesman on health matters for the CNPF told me that the medical profession should 'put its house in order' by limiting the number of doctors trained, and disciplining those guilty of overprescribing or issuing unwarranted 'arrêts de travail'. In addition he argued that the medical profession had to accept the notion that 'health care has a price' and that this price has to be one of the factors considered by doctors when making their diagnosis.

The representatives of the CNPF that I spoke to had little sympathy for the CSMF. In their view the activities and policies of Dr Monier were incomprehensible. As they saw it, the medical profession wanted 'to have their cake and eat it' by wanting to maintain the system of liberal medicine, and at the same time wanting their income guaranteed by the State without having to accept any constraints on their freedom

in return. The officials of the CNPF declared themselves pleased on the whole with the third convention which they believed was the first step towards recognising their call for greater responsibility for the costs of health care to be transferred to the consumer.

Despite their clear public statements about the organisation of the health system, the practice of playing a part in administering the existing system poses a number of dilemmas for the CNPF. Their main objective is clearly to reduce the cost of the health system to employers. This can be achieved either by reducing the cost of the health system as a whole or by at least reducing the rate of increase of health spending, or alternatively by reducing the proportion of the bill paid by the employers. The latter has always been and remains a major objective of the employers' federation, but one that cannot be furthered by the federation in their role as administrators and policy makers of the Health Insurance Funds. In this second role their main objective must be to reduce the rate of increase of the health budget. But the CNPF also represent the manufacturers and producers of medical equipment and the drugs that have fuelled the explosion of health costs. The CNPF are also the champions of free enterprise, deregulation and individual choice. Given the above it is difficult for them to openly advocate or propose a rationing of health care or to consider replacing the 'système libéral' with a possibly cheaper more easily controllable but nationalised health system. Not only would the CNPF have alienated a large proportion of its membership by following such policies, but it would also have made it impossible for it to continue to act as the champion of free enterprise in other sectors of the economy.

There was thus a basic contradiction in the attitudes of the CNPF.

Given their own way they would have opted for a complete dismantling of the system. Forced to operate within the confines of the existing institutions the solutions they proposed were half-hearted and of a short term nature. Short term financial policies using the 'Convention Nationale' as the basic instrument of cost control combined with appeals to the medical profession for self-regulation remained the basic policy tool of the CNPF. In this case, there is no evidence of class influencing the decision of the Health Insurance Funds. In fact the reverse is true, as both the medical profession and the employers saw each other as obstacles to achieving their aims. On the other hand, however, the CNPF has done little to challenge the power and influence of the medical profession. Their commitment to the free market and, by extension, to 'la médecine libérale', virtually excludes any other policy initiative and ensures the continuance of the status quo.

6.vii. **The Trade Unions**

Although the CNPF has been the dominant group on the administrative councils of the Insurance Funds since 1967, the representatives of the Trade Unions are still potentially important actors in the policy making process. Their influence, however, as in other areas of French political life, is reduced by the ideological difference that separate them.

The 'Confédération Française Démocratique du Travail' (CFDT) has evolved from its origins as an offspring of the Catholic Church to its present position close to the Socialist Party, but is still careful to maintain its image as independent of any party or government.

Like the CNPF, the CFDT dismisses the theoretical powers of the Health Insurance Funds as of no consequence. According to Christian

Ramft, the spokesman for the CFDT on social security questions, 'c'est clair que c'est le gouvernement qui tire les ficelles'. However, true to their image as pragmatists, the CFDT do not condemn government policy out of hand and do not deny that the administrative councils of the Insurance Funds on which they serve provide some scope for influencing government decisions. Thus, according to Ramft, a complicated game takes place in which each party attempts to influence the other and to alter policy decisions, while at the same time denying all responsibility for policy making. As a result the relationship between the CFDT and the Government is conflictual, with the former never claiming to be satisfied, but prepared to recognise in private that some of their proposals had been implemented and the latter in turn refusing to recognise the real paternity of certain policy decisions.

Ramft also argued that within different areas in the field of social policy, different 'rapports de force' existed. Thus for example he pointed out that in the area of family allowances, pensions and other benefits, while the government decided who should be eligible for what benefits and their value, the unions often made important contributions to the small print of the law by, for example, persuading policy makers to simplify the claims procedure, or to cater for certain unforeseen circumstances. In short Ramft's claim was that the participation of the unions helped to make policy more responsive to the needs of the people for whom it was designed. However, according to Ramft, the area of health policy was the exception to the rule, remaining, as he put it, the 'chasse gardée du patronat et du gouvernement'. His explanation for this was that the financial and economic importance of this area of policy is such that the unions were excluded from all negotiations, and were hence unable to influence decisions in any way. This also meant

that the only channel left open to influence policy in this field was through pressure brought to bear outside the constraints of the health insurance institutions, in the traditional form of strikes and street demonstrations. According to Ramft this approach was not ineffective. He believes that the demonstrations organised by the CFDT and others during 1979 prevented the introduction of a plan devised by Farge and Giscard which would have allowed all doctors to fix their tariffs freely, with a flat rate for the refund of medical costs.

The CFDT identify two separate periods in government health policy. In the first, coinciding with Chaban-Delmas' 'Nouvelle Societé' programme, they saw the government following a policy of seeking negotiated agreements with all parties through a process of mutual compromise. This produced the first national convention which the CFDT supported in principle, while remaining critical of the results of the negotiations which, in their view, showed that the government was incapable of resisting the demands of the medical profession. The end result, in their view, was that the government failed to take the necessary measures to coordinate and to control medical practice to ensure that the system of national tariff agreements effectively reduced health spending. They also argued that Article 18 of the Convention, in which the insurance funds agreed not to create any new health centres themselves, and not to grant third party payment agreement to groups wanting to open such centres, stacked the cards in favour of 'la médecine libérale'. Health policy during this period, despite the above, was seen by the CFDT to be based on laissez-faire attitudes with a corresponding absence of any long term health strategy. During this period the CFDT nevertheless felt that they had some, all be it small, influence on health policy.

After 1975 the CFDT identified a new approach by the government. They argued that in reaction to the apparent failure of the negotiations with the medical profession to bring down health costs, the emphasis of government policy had changed. At the same time, escalating inflation and rising unemployment increased the financial difficulties of the 'la médecine libérale'. As a result, according to Ramft, the government changed its approach, replacing the carrot with the stick. The new approach of government is illustrated by the annual increases in doctors' tariffs granted under the convention system between 1975 and 1980. They were well below the level of inflation (see following tables of Tariffs established within the 'Conventions Nationales').

The alternative health policies championed by the CFDT placed a major emphasis on the general practitioner, and rejected the path of what was called 'hospitalo-centrisme', or the reliance on large sophisticated hospitals as the basis of health policy. This attachment to primary health care helps to explain the cordial relations which developed between the CFDT and the CSMF, culminating in the joint demonstrations against the 1980 convention. The CFDT argued that health policy must be conceived as part of a comprehensive project, and that a rational health policy implies a total change in the system of production. For example, they argued that it is irrational on the one hand to have a system of production which produces ill health, and on the other a health system to repair the damage. A rational system in their view would only be achievable through a series of reforms reaching far beyond what is normally considered the domain of health policy.

The basis of the health system favoured by the CFDT would be facilities of a human size, responsive to the needs of a community and

Tariffs established within the 'Conventions Nationales'
(for Consultation)

FF

CONSULTATION	ZONE	1.5.69	1.5.70	1.11.70	1.5.71	1.11.71	1.7.72	15.11.72	1.1.73	1.5.73	1.5.74	1.9.74	1.1.75	1.4.75
General Practitioner	A	16	17	17	18	20	21	22	22	22	23	25	27	27
	B	15	16	16	17	19	20	21	21	21	22	24	26	26
Specialist	A	28	29	29	30	32	33	34	35	35	37	39	41	41
	B	26	27	27	28	30	31	32	33	33	35	37	39	39
Psychiatrist	A	40	41	41	44	47	48	50	51	51	54	56	59	59
	B	37	38	38	41	44	45	47	48	48	51	53	56	56

CONSULTATION	ZONE	15.6.75	1.11.75	1.7.76	1.11.76	15.5.77	1.10.77	1.1.78	15.2.78	1.5.78	15.7.78	15.10.78	26.2.79	1.6.79
General Practitioner	A	29	30	32	32	33	34	34	35	35	38	38	40	40
	B	28												
Specialist	A	44	45	48	48	50	51	51	53	53	57	57	60	60
	B	42												
Psychiatrist	A	65	70	75	75	78	80	80	83	83	88	88	92	92
	B	62												

(Source: Statistiques de l'année 1979, CNAMTS, Paris 1980. pp76/77)

Tariffs established within the 'Conventions Nationales'
(for Home Visits)

FF

HOME VISITS	ZONE	1.5.69	1.5.70	1.11.70	1.5.71	1.11.71	1.7.72	15.11.72	1.1.73	1.5.73	1.5.74	1.9.74	1.1.75	1.4.75
General Practitioner	A	22	24	25	26	27	27	29	29	34	35	35	37	37
	B	20	22	23	24	25	25	27	27	32	33	33	35	35
Specialist	A	38	38	38	39	40	40	40	40	47	48	48	50	50
	B	34	34	34	35	36	36	36	36	44	45	45	47	47
Psychiatrist	A	56	56	56	57	59	59	59	59	66	67	67	70	70
	B	50	50	50	51	53	53	53	53	61	62	62	65	65

HOME VISITS	ZONE	15.6.75	1.11.75	1.7.76	1.11.76	15.5.77	1.10.77	1.1.78	15.2.78	1.5.78	15.7.78	15.10.78	26.2.79	1.6.79
General Practitioner	A	38	40	42	44	45	47	49	50	50	50	53	53	58
	B	36	38	40										
Specialist	A	52	55	57	60	62	64	66	68	68	68	71	71	76
	B	50	52	55										
Psychiatrist	A	74	80	84	88	91	94	97	100	100	100	103	103	108
	B	70	78	82										

(Source: Statistiques de l'année 1979, CNAMTS, Paris 1980. pp76/77)

providing primary and preventive care - in other words the health centre. 'La Médecine Libérale' would not be suppressed, but rather the consumer would be able to choose freely between the two.

The 'Confédération Générale du Travail' (CGT), the largest of the French labour unions and closely linked with the French Communist Party, was the most seriously affected by the 'Ordonnances' of the 12th August 1968. At the last elections for the 'Conseil d'Administration' of the Health Insurance Funds in December 1962, the CGT received 44.3% of the vote, trailed by the CFTC (now CFDT) with only 20.69%. The CGT thus had by far the most important place on the administrative councils of the 'Sécurité Sociale', and controlled the majority of 'caisses'. After 1967 the CGT were offered 17% of the seats on the new administrative council, the largest proportion allocated to a union, but far below their previous strength. When the social security institutions were reformed in 1967 there were 1,671 administrators of the local 'caisses' appointed by the CGT. By 1981 this number had fallen to 929.[28]

Both the CGT and the CFDT strongly opposed the introduction of the system of 'administration paritaire'. The CFDT has shown its opposition by regularly voting against the annual budget of the fund. The CGT adopted more drastic tactics by refusing to take up their seats on the administrative council. The effect of the 1967 reforms was far greater however on the CGT than on the other unions, as it meant that the CGT, and inter alia the PCF, lost control of an institution that had been created by a communist minister, and was seen as a shining example of what might be achieved by 'des luttes ouvrières pendant plusieurs décennies'. Finally, in losing control of the administrative councils of the Health Insurance Funds, the CGT and the Communist Party also

lost an important source of patronage, and a training ground for future party cadres.

According to the CGT, the prime objective of government health policy was to reduce the charge of financing the health system on industry, and the budget of the State. In the language of the CGT the result of government policies is the 'casse du système de santé'.[29] In this perspective, government's efforts to shorten the average length of hospital stays were described as being the 'renvoi prématuré ou accéléré des malades à domicile'. The attempt to control and set guidelines for the medical profession was seen as being 'une limitation autoritaire des moyens thérapeutiques'. The policy of keeping elderly patients and the mentally ill out of hospital and at home for as long as possible, and the debate on preventive medical techniques, were dismissed as being:

> La recherche de soi-disant nouvelles formes de prise en charge des soins, non en fonction d'une adaptation du potentiel à des besoins nouveaux, mais en fonction de la recherche du moindre coût... Le malheur c'est que derrière des intentions qui se veulent louables, la seule recherche est celle des économies. Non seulement pouvoir et patronat ne mettent pas de moyens réels au service de leurs bonnes intentions, mais ils s'en servent pour casser ce qui existe.[30]

All developments in the health sector were interpreted by the CGT in terms of class struggle. The government and 'patronat' in their view were bent on running down the health system, and any positive developments were seen as the result of 'les luttes de la classe ouvrière'. As an example the decision of the Préfet du l'Aube to include funds in the regional budget for the construction of a hospital at Romilly sur

Seine was described by the CGT health federation as the result of the initiative of the local branch of the CGT which collected a petition with 300 signatures in favour of the project. In another case the Prefect fixed the annual increase of the budget of the public hospital in Chalons sur Marne at 11.8%, but again, according to the CGT health federation, 'La tenacité du personnel de la CGT n'a pas permis que se réalisent les objectifs du pouvoir', and the budget increase was raised to 16.43%.[31]

At the same time as they attacked the government and the 'patronat', the CGT also directed criticism with almost equal force at the CFDT and the Socialist Party. These were accused of being 'réformistes traditionneles' following the same policies as the government disguised behind a different language. Thus the CGT rejected the idea of encouraging different forms of medical practice like preventive care, and any suggestion that too much medicine could be harmful. On the contrary, the CGT was fully in favour of a high tech hospital based health service.

The CGT refused to accept that government spending on health was excessive. According to G. Marchais, 'Le service public de la santé doit répondre aux besoins de la population et non pas aux critères de la rentabilité'.[32] The CGT also rejected attempts to control the quality of health care as misguided. In their view it was more important to remedy the inequalities in the health status of the population by providing more doctors, more prescriptions, more hospitals, more X-rays, and more sophisticated equipment.

The clue to understanding the position of the CGT can be found in their analysis of the reasons for the crisis of the social security system.

This they saw as part of the international crisis of capitalism, and all the attempts of the government and the 'patronat' to reduce the cost of the health system as part of attempts at managing the crisis for the maximum benefit of multi-national capital. In this perspective it was in the interests of the CGT to make maximum demands in order to hasten the collapse of the capitalist system. In the words of the secretary general of the 'secteur social' of the CGT, 'C'est pas à nous de gérer la crise du capitalisme'. The demands of the CGT were therefore not primarily aimed at improving health services, but rather part of a much wider strategy. Thus the CGT argued that there is no 'crise de la sécurité sociale', but only an attempt by the government and the 'patronat' to

> culpabiliser les travailleurs et le corps médical... Le gouvernement a volontairement dramatiser l'évolution des dépenses de santé et présente la Sécurité Sociale comme un gouffre financier portant en lui 'la catastrophe économique'.[33]

6.viii. **The Health Insurance Administration**

The Health Insurance Funds, as well as being the sum of the various groups described above, also had an identity of their own. Despite the many changes that have occurred since the organisation was created, the Health Insurance Funds are still to a certain extent imbued with the generous principles of the founders of the system, and despite the reforms introduced in 1967, the influence of the Communist Party within the administration of the funds still persists. Nevertheless since 1967 a more professional and management orientated staff have come to the fore with as their prime objective to balance the budget of the 'Sécurité Sociale'. Thus within the institution itself there has developed a certain amount of conflict about what its functions should be, and as a result

a certain amount of contradiction within its policy output.

The 'Sécurité Sociale' is made up of a number of separate health insurance funds of various sizes, but the 'Caisse Nationale d'Assurance Maladie des Travailleurs Salariés' (CNAMTS), which covers 75% of the population and 80% of all health spending, is by far the largest and effectively dominates the negotiations with the medical profession on the 'Conventions Nationales'.

Since the 1967 reforms the role of the national organisations has been considerably strengthened. The local 'caisse' are now little more than administrative offices for the purpose of processing health insurance claims. The hierarchical structure that exists within the State administration has to a certain extent been copied by the 'Sécurité Sociale'. Below the national funds, at the various geographical sub levels there are units of the insurance funds. Thus in each Region there is a 'Caisse Régionale de la Sécurité Sociale', in each Department a 'Caisse Départmentale de la Sécurité Sociale', and finally the 'caisse primaire' which, although they don't correspond in area with the municipalities, are the basic units of the 'Sécurité Sociale'. At each of these levels there is an administrative council made up of the various parties described above, which acts as a sub-legislature, and a director and administrative staff who act as the executive. Despite the fact that the independence of these local units has been reduced over the years, they still maintain a certain degree of freedom of action. Evidence of this will be provided in the following chapter which describes the local implementation of primary health care policy, and specifically the experience of the 'Centre de Santé Grenoble'.

The functions of the Health Insurance Funds are set out in the 'Code

de la Sécurité Sociale'. Although central government determines the 'prestations' (or who gets what), and the 'contributions' (or who pays what), according to Ceccaldi, the Insurance Funds, unlike other sectors of the Administration, still 'possèdent des larges pouvoirs'.[34] The 'Conseils d'Administration' of the Health Insurance Funds are responsible for recruiting their own administrative personnel, and the health funds are also free to disburse as they see fit the funds from the 'Fonds d'Action Sanitaire et Sociale', representing 1% of all health insurance contributions. Most important of all, it is the 'Conseil d'Administration' of the Health Insurance Funds that negotiates the 'Convention Nationales' with the medical profession.

In theory the 'Conseil d'Administration' has considerable scope for influencing the direction and nature of health policy. Again it is Ceccaldi who argues that 'les pouvoirs donnés aux organisme de l'assurance maladie, font de la sécurité sociale l'un des acteurs privilegiés de la politique de la santé'.[35] But can this influence be seen at work in the evolution of policy during the seventies, and the three national conventions?

I have already argued that from the outset the role of central government was crucial to the success of the conventions. The first convention was only signed after the Council of Ministers pledged to maintain the system of liberal medicine, and after the Budget Ministry had given assurances on tax concessions to the representatives of the profession. Throughout the seventies it is possible to identify intervention by the government in the process of negotiations between the two parties, and to follow the evolution of government policies through the conventions. This is hardly surprising given the importance of

the funds involved and the impact of decisions taken by the Health Insurance Funds on other sectors of the economy.

In this perspective the original policy objectives of the government can be identified as being social. Initially the aim was to extend full health insurance coverage to all the population, and in so doing to ensure equality of access to health care. Indeed this was one of the main justifications for a national tariff agreement. By 1979 over 99% of the population was covered by health insurance, and the objective largely achieved. However, one by-product of this success was rising costs which became the main policy problem of the second half of the seventies. This coincided with the worsening state of the economy during the seventies which further emphasised the problem.

Although the control of health spending increasingly became the main concern of health policy makers, given the ideological importance of the principles of the 'la médecine libérale', and the widespread public support for the existing system of health provision, the introduction of an explicit policy of rationing the supply of health care to reduce the costs of the system was politically inconceivable. The existing institutions therefore remained unchanged, while policy makers attempted to achieve their aims by a variety of indirect measures. These involved highlighting the cost of health spending to the nation, introducing the concept of quality into the evaluation of health care, and calling for and attempting to create incentives to encourage the providers and the consumers of health care to practice greater self-discipline. At the same time government attempted to limit the level of increases in doctors' fees and to shift a proportion of the cost of health care from the Insurance Funds to the individual.

Both the Trade Unions and the 'Patronat' deny any responsibility for this shift in health policy. The Trade Unions, because of their reduced representation on the ruling council of the Health Insurance Funds have lost any decision making power they might once have had. The 'Patronat', because of the contradictions of their position, have been unwilling to play a decisive policy making role. Is the explanation of this abdication of responsibility that the independence of the Health Insurance Funds has always been symbolic rather than real? This would seem to be the case. The reasons for this are complex and go back to the origins of the institution described in chapter two, when the battle was lost to create a single insurance fund covering all forms of risk, with power to raise money from all sections of the population. The fragmented organisations that emerged were unviable and inevitably had to depend on government finance to survive. This equally inevitably meant a loss of independence. Thus although the 1967 reform was presented as being a strengthening of the independence of the 'caisse', central government out of habit maintained close control over the Health Insurance Funds. The size of the amounts involved, and their economic significance, goes a long way to explaining this. Nevertheless, the Health Insurance Funds kept their formal status as independent of the State administrative service as this served the purpose of government.

Thus although the 1967 reform increased the power of the funds to include the setting of the levels of contributions and benefits, as well as the responsibility for negotiating tariff agreements with the medical profession, in practice it could do none of these without the agreement of the government. Thus in the case of an unbalanced budget, the 'caisse' might wish to raise contributions but, given the unpopularity of such a decision, could only do so with the prior agreement and support

of government. In the first place the insurance funds do not have sufficient legitimacy to take such a decision. Secondly, given that this decision would have to be taken by the elected representatives of those who would have to pay the increased contributions, it would probably not be proposed in the first place. Alternatively, the caisse might wish to replace the fee for service system by some other system of financing primary health care. Again this would not be possible without the overt support of government. Thus, according to a spokesman of the CNPF, the Health Insurance Funds are not in a position to make policy, and only have a 'pouvoir de gestion très limité'.

How then does government channel its policy options through for implementation by the insurance funds? One way is via the director of the Health Insurance Funds and the administrative personnel of the organisation. The director and the administrative staff of the 'caisse' are government nominees, although they take their orders from the administrative council. The director is responsible for the day to day administration of the 'caisse' and for the implementation of the decisions of the 'Conseil d'Administration'. The director also plays an important back up role during the negotiations between the insurance funds and the medical profession.

The new priorities of government however are clearly illustrated by the type of civil servant being chosen to fill the administrative posts in the councils of the Health Insurance Funds. Before the explosion of medical spending, the 'Sécurité Sociale' was dominated by the prestigious 'Conseil d'Etat'. This, partly as a result of the fact that the 'creator' of the 'Sécurité Sociale' was Pierre Laroque, a 'Conseiller d'Etat'. However, the mainly legal training of these 'Conseillers' made

them less and less suitable to cope with the increasingly complicated financial problems facing the administrators of the Health Insurance Funds. During the seventies, the directors of the Funds have all been financial experts, with increasingly financial priorities. These priorities have been well expressed by C. Prieure, an ex-director of the CNAMTS and a member of the 'Cour des Comptes', who told me:

> Scarcety is a law of human society... no activity, be it of the highest priority, or the most essential, can escape this. It follows that the obligation to control, which does not mean to stop expenditure, and to organise resources more rationally, makes good sense.

The last Director of the Health Insurance Funds appointed during the Presidency of Giscard d'Estaing, was M. Coudourier, an 'Inspecteur des Finances' whose previous post was in the cabinet of the Prime Minister, Barre. According to the editor of 'Concours Medical', he was chosen specifically by Barre and given the mission to 'assainir les finances de la Sécurité Sociale'. His immediate predecessor was a member of the 'Cour des Comptes', and both, need it be said, were graduates of the 'Ecole Nationale d'Administration'.

The Director of the Health Insurance Funds is at the centre of a complex system of interrelationships. His main dealings are with the various groups that make up the 'Conseil d'Administration', but he is also subject to pressure from the 'administration de tutelle', the Ministry of Finance, and the Prime Minister's Office. External pressure comes from the various medical unions and the 'Ordre National des Médecins'. Each group tries to influence the director at the same time as seeking alliances with one or other of the groups involved with the aim of forming a majority able to push for or block specific proposals. The director

requires a large amount of tact and diplomacy in order to maintain the confidence of his 'Conseil d'Administration', at the same time as fulfilling the policy objectives of central government. In this sense he plays a role very similar to that of the prefect in local government. His is clearly a position of vital importance, but measuring the exact extent of his influence and power is difficult, if not impossible.

The health policies pursued by Government through the 'Conventions Nationales' have thus evolved over the years in response to changing conditions. Government has been able to determine these policies as a result of a number of factors. In the first place, the composition of the Health Insurance Funds makes it difficult for any clear and constant policy objective to emerge. Although there is a natural majority on the administrative council, it is a majority unwilling and unable to undertake any fundamental reform of the system. Policy has thus been short term and incremental, with any changes in emphasis resulting from government intervention. This has taken either the form of direct involvement, as during the first 'Convention', or indirect intervention through the appointment of key administrators, and behind the scenes influence. The independence of the health insurance institutions was thus largely illusory, but it is an illusion that was maintained both by Government and to a certain extent by the left, as a symbol of past achievements. However, this system of policy making by proxy has shown itself to be not the most satisfactory or efficient of arrangements.

6.ix. **The Role of Government**

If, as I have argued, the independence of the health insurance organisations is illusory, and that none of the various actors involved in the 'Conventions' has been able or willing to accept a policy making

role, and if at the same time the system of 'Conventions Nationales' is not just a simple tariff agreement, but the key to primary health care policy during the seventies, how has this policy evolved and where has the direction for this evolution come from? I have already pointed out at the beginning of this chapter that central government played a crucial role in instigating and ensuring the success of the first National Convention. It remains to be seen which government actors played the most significant role in this process and how the changing policy objectives have been pursued through the system of conventions.

In this section I will examine the role of the Ministry of Health and its Minister, the Prime Minister and the President. Each of these plays a more or less significant role in the policy making.

6.x. **The Ministry of Health**

Perhaps the most important characteristics of the Ministry of Health have already been analysed in chapter two. The Ministry is comparatively new, has been subject to frequent structural modifications, and is thus relatively unprestigious. In the last government of Raymond Barre, the Minister of Health and two Secretaries of State presided over a Ministry made up of seven 'directions', twenty-one 'sous-directions', and ninety-seven 'bureaux'. The Ministry of Health also has its own 'Corps d'Inspection', the 'Inspection Générale des Affaires Sanitaires et Sociales' (IGASS), and its own school for training health administrators, the 'Ecole Nationale de la Santé Publique'. The Ministry is also responsible for the 'Institut National de la Recherche Médicale' and the 'Centre National d'Etudes Supérieures de Sécurité Sociale'. The bureaucratic structure of the Ministry is thus typically French (see the 'organigramme for the Ministère de la Santé' on page 13).

Like other French Ministries, the Ministry of Health has proved a prolific producer of parapublic advisory commissions for which it is responsible. These range from the highly technical, like the 'Commission des Autopsies', and the 'Commission Consultative de la Transfusion Sanguine', to commissions like the 'Commission Nationale d'Hospitalisation', whose policy making functions will be described in the following chapter.

In the past the 'Conseil d'Etat' has dominated the top post in the Ministry of Health. This is a hangover from the time of P. Laroque, the creator of the 'Sécurité Sociale'. However, as pointed out earlier in this chapter, the influence of this corps is now on the wane as a result of the recent appointments of an increasing number of 'Inspecteurs de Finance', and members of the 'Cours des Comptes' to the top jobs in the Ministry.

Up until recently the 'Conseil d'Etat' shared its influence with the medical profession, which in the same way had a monopoly over certain posts in the Ministry, but this influence too has been declining. Up until the administrative reforms of 1964, the head of the local services of the Ministry of Health in the 'Départements' was always a doctor. This changed in 1964, and a 'bureaucrate', with a doctor as second in command, now heads the departmental services of the Ministry of Health. The 'Directeur Général de la Santé', the top post in the Ministry of Health, was also traditionally held by a medical man. In 1980 the structure of the Ministry underwent one of its periodic reforms, and the 'Direction de la Santé' and the 'Direction Générale des Hôpitaux' were fused into one 'Direction Générale de la Santé'. The new post was given to an 'Inspecteur Général des Finances', J. Choussat, who

had previously been responsible for supervising Ministry of Health spending at the Ministry of the Budget.

There were a number of other significant new appointments in the Ministry of Health at this time. In 1979 J. Farge, a close collaborator of R. Barre and an 'Inspecteur des Finances', was appointed Secretary of State responsible for the social security institutions. Assisting him as the head of the 'Direction de la Sécurité Sociale' in the Ministry of Health was another 'Inspecteur des Finances', Coudourier, whose previous job had been in the cabinet of the Prime Minister. Another 'Inspecteur des Finances', J. Weber, was appointed 'Directeur Général de la Pharmacie et des Médicaments', another important 'Direction' in the Ministry of Health. These appointments are significant on a number of counts. Firstly they clearly mark the decline in influence of both the 'Conseil d'Etat' and the medical profession in the Ministry of Health. Secondly they highlight the much increased importance of this area of policy making. The previous low prestige in which the Ministry of Health was held, and the consequences of this for recruitment, were described in chapter three. The appointment of high flying 'Inspecteurs des Finances' to the Ministry of Health was a sign of the increasing importance placed by the government on health policy as well as the fact that financial rather than social objectives were now the chief concerns of the policy makers.

However, one result of this influx of new blood was to accentuate the differences between the rank and file administrators in the health administration and the policy making élite. The new influx of 'high flyers' further emphasised the difference between the 'policy makers' and the implementors. The 'Inspecteurs des Finances' and the other

members of the 'Grands Corps' were parachuted into the Ministry of Health to perform a specific task. Their career prospects lay outside the Ministry and depended to a large extent on the success with which they fulfilled their mission. They shared the values and objectives of government. In contrast the line administrators within the Ministry of Health tended to spend their whole career within that ministry. They hence adopted the goals and values of the ministry as a whole. This conflict of values is illustrated by a member of the cabinet of the Minister of Health who described the rank and file of the administration as being imbued with what he described as 'the ethic of public service and the philosophy of the intérêt général', and on the other hand by a doctor in the Ministry of Health who described the new ministerial team in the following terms: 'cette nouvelle équipe, ce ne sont que des boutiquiers', a disparaging reflection on their preoccupation with financial matters.

In conclusion, however, I would argue that the main feature of the policy making function of the Ministry of Health is its apparent absence. The Ministry of Health is a small administration, both in terms of staff employed and in budget. The majority of its personnel are employed in the departmental field services where their main function is to ensure the public health and safety regulations are respected. The existence side by side with the Ministry of Health of the formally independent Health Insurance Funds, which administer a budget as large as that of the official State budget, creates a confusion as to the source and content of policy. The making of primary health care policy is shared between these two institutions, with the Minister of Health and his immediate colleagues most involved in the process.

6.xi. **The Minister of Health**

Successive Ministers of Health have had a more or less visible influence on Health Policy. R. Boulin, Minister of Health at the beginning of the decade, promoted the major reform of the French Hospital system analysed in chapter five. Michel Poniatowski's stay at the Ministry of Health was short and unremarkable. Simone Weil greatly increased the prestige of the Ministry as a result of her personal popularity and growing political importance. Some argue that, for the same reasons, she left a number of important decisions unresolved, and avoided tackling, in any way but rhetorical, the problem of rising health costs. Jacques Barrot, her successor, was left to pick up the pieces and deal with what had become a critical problem.

It is possible to identify three broad phases in the development of primary health care as expressed in the 'Conventions Nationales', none of them however corresponding neatly with the stay in office of any particular Minister. As I have already argued, the initial objectives of the convention were social, in the sense that the main aim was to extend health insurance coverage to all of the population. This also coincided with Chaban-Delmas' new society programme, and thus fitted in well with the wider political objectives of the government. However, the first convention also contained references to the need for the control of escalting health costs, and by the time the second convention was signed, the oil crisis and its economic repercussions, meant that these financial considerations gradually came to supercede the original social objectives of the system of national conventions.

This new concern for rising costs was reflected in the increasingly bitter tariff negotiations between the health insurance organisations

and the medical profession. Nevertheless the nature of the system of fee for service payment meant that, while tariffs could be blocked, the volume of medical activity, and hence health costs, could not be controlled. Throughout this second phase the government relied on the system of TSAP or in other words professional self-regulation as the sole means of controlling the volume of health care provided. The table in chapter five (page 157) illustrates that this strategy was unsuccessful, with health costs continuing to rise at a rate well above that of inflation throughout the decade.

The period between 1974 and 1979 can be seen as an interregnum during which 'laissez faire' incremental approach to the problem was followed. A more interventionist and concerted approach to the problem was adopted after 1979 with the appointment of J. Barrot as Minister of Health and J. Farge as Secretary of State for social security.

Barrot presided over a number of important changes in the health policy sector, but it is not clear that his appointment was the crucial factor. Although Simone Weil made little impact on the system of national conventions, it might be argued that this was because her priorities were different. It is also possible to argue that she deliberately avoided this policy area with the blessing of the President, in order to avoid difficult and potentially unpopular decisions, and thus preserve her political usefulness to the government. Barrot on the other hand was appointed with the specific task of solving the problem of rising health costs, according to the editor of 'Concours Médical'. He was also appointed at more or less the same time as a team of highly qualified top civil servants who were given the same brief. It is thus possible to argue that his authority and his influence on policy came directly

from the Prime Minister, and in that sense that the policy changes post 1979 were not strictly speaking directly the result of his appointment.

Finally the 1980 convention which included a number of significant changes was negotiated between the medical profession and the health insurance organisations. When Monier of the CSMF called for a meeting with Barrot to protest against the proposed terms of the convention, the Minister refused to see him, arguing that he had no authority to intervene. He maintained the position throughout, despite the strikes and demonstrations organised by the CSMF before and after the signing of the agreement. The exact extent of the influence of Barrot therefore is difficult to ascertain, although it does appear that the impetus and the necessary authority for these changes came from the next level up the government hierarchy.

6.xii. **The Prime Minister**

According to the constitution of the Vth Republic the responsibility for determining and coordinating policy lies with the Prime Minister. Moreover, health policy is perhaps one of the few areas that has not been claimed as part of the widening 'domaine reservé' of the President. That the Prime Minister played an important role in influencing primary health care policy should not come as a surprise. Although when Barre became Prime Minister in 1976 the rate of the increase in health spending was already a serious problem, his influence only became apparent after 1979. Thus it seems that Prime Ministerial involvement in this area was not the norm, but a response to particular conditions.

R. Barre became Prime Minister after the more or less forced resignation of Jacques Chirac. His appointment gave President Valery Giscard

d'Estaing more freedom to follow his own policies through his own Prime Minister but this influence only became apparent in the health area in 1979. The reason for this may be that the Prime Minister only turned his attention to the field of health after other policy priorities had been tackled, and as the problem of the budget deficits of the Health Insurance Funds continued to cause problems.

The changed policy priorities as expressed through the third convention clearly reflect the changed ideas and philosophy of the new government. The 'conventions' were a classical example of 'Gaullist' populist ideology, in that the system combined generous social objectives, the participation in decision making of professional and labour groups, and compromise as the basis of decision making. The government of R. Barre and Giscard d'Estaing represented a very different tradition. In many ways their philosophy resembled that of Margaret Thatcher, but in terms of policies the comparison cannot be stretched too far, as the starting point and the cultural context differ so greatly.

In a variety of policy areas the government of R. Barre set about removing the long standing state controls at the same time as it sought to encourage the 'free market'. One of the key concepts of this government was what was called the 'politique de la liberté des prix'. The influence of these ideas is evident in the creation of the 'secteur libre' introduced in the third convention. The 'secteur libre' allowed doctors to opt for a free market situation with no controls over their tariffs, with a standard rate of refunds to the consumer. It is possible to interpret this as a first step towards a complete reform of the health insurance system, with the concept of a comprehensive health insurance coverage being replaced by a system based on a fixed minimum coverage

for all, financed by the State and supplemented by private health insurance according to the ability of the individual to pay. Subsequent events mean that it is impossible to tell if this was the case.

However, there is a second possible interpretation which seems more plausible. Given the long history of State intervention or 'dirigisme' in France, it is unlikely that the government of R. Barre ever intended allowing market forces a completely free rein over the economy. Instead, the objective was to stimulate the State owned or State controlled sectors of the economy by creating the conditions for competition from parallel private sectors, in order to promote productivity and efficiency. The introduction of the 'secteur libre' in the health policy area therefore should not necessarily be seen as part of any long term plan to dismantle the existing system, but as part of the implementation of a broad economic philosophy applied to the health field rather later than to other policy areas, but applied nevertheless because there was no reason why health should be exempted.

Yet another possible interpretation is that the third convention illustrates the strength of influence of certain interest groups such as the CNPF and the FMF on the policies of the Barre government. The third convention marked a return to the state of affairs prior to the first convention in that it allowed doctors to opt out of the system without being penalised, thus satisfying one of the demands of the FMF. The introduction of the 'enveloppe globale', and the attempts to enforce the TMOP more effectively can be seen as a clear response to the call on government made by Y. Chotard of the CNPF to make the individual more responsible for health spending and to reduce the overall cost of health care while at the same time not curtailing the freedom of the

provider. However, while these influences were clearly present, there is no obvious linkage of cause and effect. The most plausible explanation is that the 1980 convention was the natural extension of the economic philosophy of the government to the health policy area, rather than the result of the sinister influence of small and unrepresentative pressure groups.

6.xiii. **The President**

Analysts of the French political system generally agree that the power and field of influence of the President of the Republic has been significantly increased by successive incumbents since the beginning of the Vth Republic (see chapter one). While this may be so it is nevertheless far from clear to what extent certain policies or changes in policies can be explained in terms of Presidential power. As Wright argues, one of the weaknesses of the President of France is the very extent and range of his power. The considerable and varied responsibilities of the President mean that his attention is dispersed, and hence that his influence which certainly may be determinant in some cases is very often only passing, and hence in terms of the final impact on policy, only marginal.[36] Health is one area that has not been classified by analysts as being within the field of Presidential purview. Does this mean that the process of policy making is any different from other areas, or is it simply that health policy has been overlooked by analysts and that the President does intervene as with many other policy areas... but that his intervention is occasional and of only limited importance?

I argue above that it is possible to interpret the changes introduced by the third convention as products of the economic philosophy of the Barre government. By the same token these changes can be traced

back to the President as the authority for the implementation of these policies and the source of the basic principles of the philosophy which inspired these policies. However, the link between general economic principles and their policy manifestations remains tenuous however. In the health field Giscard always remained detached from the daily policy infighting and the detailed negotiations of the conventions.

The advantage of this detachment was that although the third convention had been rejected by the medical profession, and the Minister of Health and the Prime Minister stood accused of attempting to dismantle the health service by Monier, the President of the CSMF, and by the Trade Unions and the parties of the left, Giscard d'Estaing was able to declare to the 'Académie de Médecine':

> Il est essentiel de maintenir les relations d'étroite coopération qui se sont établies entre le corps médical et les organisations de sécurité sociale et qui ont permis à la fois de préserver la qualité de l'acte médical et d'assurer un niveau de remboursement équitable. Le système conventionelle doit être sauvegardé dans un climat de confiance réciproque... La médecine d'exercice libéral, généraliste ou spécialiste est la médecine de demain.[39]

The extent of the President's involvement in health policy making therefore remains unclear. What is clear is that the new emphasis on 'freedom of choice' and 'greater individual responsibility', introduced with the 1980 convention, fitted well with other aspects of the economic policies of Barre and Giscard. Thus while there is no evidence of direct and frequent intervention by the President in the field of health policy, the evolution of policy suggests that, through the appointment of the Minister of Health and other key personnel in the Ministry of Health,

the President indirectly influenced the course of affairs.

6.xiv. **Conclusion**

In conclusion the system of 'Convention Nationale' throughout the seventies has been far more than a simple tariff agreement between the medical profession and the health insurance organisations, but the main feature of successive governments' policies towards primary health care. All the various actors involved in the process of negotiating and administering the health system have different and often conflicting interpretations of the policies followed by government through the three agreements negotiated between 1970 and 1980. The particular nature of the institutions of the Vth French Republic, the power of the President, the lack of power of the political parties and Parliament, or the nature of the Administration on their own or combined, do not enable a full explanation of the evolution of these policies and the policy making process. More relevant and of far greater importance was the particular nature and background of the health institutions. These provided both the institutional context and the actors involved in the process. The multiplicity of the policies proposed reflecting the multiplicity of actors involved, making incrementalism inevitable. The theoretical separation of the institutions from government meant that the policy makers lacked the legitimacy to introduce radical reforms. At the same time this separation allowed the government to distance itself from the product of the policy while effectively controlling the process. As a result, the roots of the problem of escalating health costs, and the system of fee for service payment in conjunction with comprehensive insurance cover, was not tackled.

Chapter Seven

THE IMPLEMENTATION OF PRIMARY HEALTH CARE POLICY IN THE RHONE-ALPES REGION

7.i. Introduction

The issue of centre-periphery relations in France is a major theme in the literature on French politics and government. My initial research plan was to take two policy case studies (in the event, primary health care policy and hospital policy) and to compare and contrast the way in which each was implemented in two selected regions much in the way J. Milch compared the policies of Nice and Montpellier.[1] If the same formal and informal structures apply to the field of health policy as to other policy areas, the same sort of questions as those posed in the literature on French government and politics analysed in chapter one should be equally relevant. What is the role of the Prefect? What influence does the 'Maire' have on local decisions? What is the role played by the field services of the Ministry of Health? And what is the nature of the inter-relationship between central government, the local services of the Ministry of Health, the Prefect, and the local political élite?

However, while this approach proved satisfactory for dealing with hospital policy, it could not be adapted to the issue of primary health care. As a result of the commitment of the government and policy makers to 'la médecine libérale' and the fee for service payment system, the local dimension of the policy process appears less significant. There is an apparent consensus on the nature of the health system between the centre and the periphery. I have already pointed out that the vast majority of doctors in France practice 'la médecine libérale'. The role

of Government in the implementation of primary health care policy is thus, for the reasons explained in the preceding chapter, minimal. The essence of the fee for service payment is that each doctor within the system is the primary decision maker, and while there are certainly differences in the way individual doctors may take decisions, an analysis of this would not be within my competence, and would reveal little of interest to the political scientist.

I have therefore adopted an alternative approach, and concentrated my attention on the 'Centre de Santé de la Villeneuve de Grenoble', an experimental health centre promoted by the then Socialist municipality. The reason of this is two-fold. I have purposely selected the exception to the rule as the conflicts that surrounded the centre highlight the inner logic of the system. They thus enable a fuller understanding of what 'la médecine libérale' means in terms of the type of health care provided to the consumer than would be obtainable by focusing on the 'typical' case. Secondly, the experience of the 'Centre de Santé de la Villeneuve de Grenoble' followed on from a local policy initiative which went against the dominant ideology of both the medical profession and central government. This contrasts with the subject of my second case study, hospital policy - a policy initiated and imposed by the centre and hence very much in harmony with the dominant ideology. The methodology chosen here is therefore justifiable both in terms of the contrast and similarities it serves to highlight, but also in that it enables us to address those questions mentioned above, which would otherwise have remained unanswered.

7.ii. **The Centre de Santé de la Villeneuve de Grenoble**

The 'Centre de Santé de la Villeneuve de Grenoble' was created in

1973 on the initiative of H. Dubedout, Mayor of Grenoble and a group of doctors dissatisfied with the traditional forms of medical practice. The centre began to take shape in the late sixties, with the beginning of a new housing development on the outskirts of Grenoble, which was planned and largely financed by the municipality. One of the guiding principles of this project was that it was conceived as a self-contained unit. Thus the architect was asked to provide space not only for schools, shops and sports facilities, but also for a health centre. The municipality of Grenoble saw this as a chance to gain a foothold in one of the few aspects of the life of the town from which they were excluded. They encouraged a small group of doctors, who were dissatisfied with the way the health system worked, to organise a series of public meetings to discuss the kind of centre that should be created, and the type of medicine it would provide. It was at these meetings that the organisational framework and the objectives of the centre were first formulated.

The health centre concept was not new. Hence the municipality and the doctors were able to look for examples and advice to both Marseilles and Paris, where such organisations had been in existence since the beginning of the century. These institutions had been created by local 'mutuelle' societies, private health insurance organisations often controlled by one of the many trade unions to provide an alternative place of treatment for their members, rather than refund the cost of expensive private treatment or subject their members to the uncomfortable and poor standards of public hospitals. Their main role now is as second complementary insurance organisations which refund the 'ticket modérateur', the 25% of medical expenses not covered by the 'Sécurité Sociale', but they still run their own clinics and surgeries. The Paris and Marseilles Centres both had third party payment arrangements with

the social security organisations. Doctors in these centres were salaried and treatment provided free of charge, but the 'type' of medicine they delivered differed little from the traditional style of practice. They were administered by associations dominated by the CGT, the Communist controlled union. This was not the type of health care which the doctors of Grenoble wanted, and for a medical model they looked to the local Community Health Centres of Quebec. These were small centres with intradisciplinary medical teams which aimed to provide a wide range of medical and social services to the community in which they were situated. The Health Centre of Grenoble, like those of Quebec which it closely resembles, aimed not only at providing a convenient system of general medical care, but also a qualitative change in the nature of that care.

The administrative organisation of the centre drew heavily on the experience of the Paris and Marseilles Centres. An association to administer the centre was formed by the two mutual societies that existed in the Department - the 'Union Mutuelliste des Travailleurs' (UMUTRA) controlled by the Communist CGT, and the 'Union Departementale des Sociétés Mutuellistes de l'Isère' (UDSMI), theoretically apolitical but close to the Socialist Party and the CFDT.

The medical model drew on the experience of the local Community Health Centres of Quebec. The type of health care that the doctors at the centre sought to provide was based on the following main principles:

1. Free medical treatment achieved by arranging a third party agreement (i.e. 'tiers payant'), to ensure equal access for all to the centre, and to break the link between payment and treatment.

2. A multidisciplinary medical team to end the isolation of the general practitioner and to facilitate the flow of information between doctor and specialist.

3. The pivotal role of the general practitioner, practicing a 'médecine lente' (slow medicine) in which the individual and his environment are stressed, as opposed to the symptoms.

4. The development of preventive medicine.[2]

By 1981 the Centre employed fifty people, made up of secretaries, an administrative staff, nurses, and a multidisciplinary medical team, including five full time generalists as well as paediatricians, rheumatologists, psychologists and gynaecologists, working at the Centre on a part time basis. All the staff were employed on a salaried basis. Initially the municipality took no part in the administration of the Centre, though financial problems were soon to change this. The Centre had negotiated a third party payment agreement with the 'Sécurité Sociale', ensuring that it could meet one of its principle objectives, the provision of free health care. However, the income of the Centre under this system remained dependent on the number of 'actes' performed by the doctors of the Centre in the face of continuing financial problems. The UMUTRA representatives in the Centre's administration suggested that doctors increase the number of 'actes' performed and change the style and organisation of the medical team. The Communists of the UMUTRA resented the fact that the Socialist Party was taking the credit for what they regarded as their conceptual brainchild. In addition they had little sympathy for the 'autogestionnaire' principles adopted for the internal organisation of the Centre. When the UMUTRA failed to get the changes it had called for, it withdrew from the 'Conseil

d'Administration', where its place was taken by representatives of the municipality. The municipality also took over the Centre's budgetary deficit and provided an effective subsidy by buying the Centre's medical equipment. This meant that the municipality, which originally had encouraged the Centre in its infancy, but refrained from entering into any formal contract with it, was now clearly and openly associated with it, and hence accepted its share of the responsibility.

The creation of the Centre met with a hostile reaction from the medical community of Grenoble, which was noted for its conservatism. The doctors of the Department of the Isère were one of the last groups to sign the 'Convention Nationale' which fixed the rates of doctors' honoraria, and the FMF, the more conservative of the two medical unions, counts Grenoble as one of its strongholds. The President of the local branch of the FMF described the Centre as a 'septicaemia'. The FMF also claimed that the Centre was a political exercise and that its chief objective was to promote the Socialist Party.

The practical result of this hostility was a virtual 'blacking' of the Centre by a large part of the medical community. The well equipped X-ray department and the laboratory were underused despite their excellent facilities, and few general practitioners in private practice in the town referred their patients to the specialists at the Centre.

Nor was the Centre welcomed by local government representatives. Initially planning permission and authorisation for certain items of equipment was required from the Prefect. Although this was never bluntly refused, the decision was delayed on a number of occasions. When the Centre eventually opened, it was without the Prefect's formal

authorisation. This was only possible as a result of the strong support of the Mayor of Grenoble who, because of the size of the town he runs, and his political status, enjoys a certain amount of independence vis-a-vis the Prefect.

However, the 'Centre de Santé' found an unexpected ally in the 'Direction Départementale de l'Action Sanitaire et Sociale' (DDASS). One of the most dependable sources of income for the Centre turned out to be the regular contracts it received from the DDASS. The French State has a long tradition of providing certain forms of preventive care. These preventive programmes tend to be directed towards mothers and young children and reflect an age old concern with the birth rate and demography. One of the functions of the DDASS is to administer 'Protection Maternelle et Infantile' (PMI) and the 'Santé Scolaire' programmes. In Grenoble the DDASS contracted out these programmes to the 'Centre de Santé'. This provided the Centre with a useful and regular source of income, without which it might not have been able to survive. This cooperation between the DDASS and the Centre was the result of good informal relations between the Director of the departmental services and a Socialist Party member active in the administration of the health centre. The informality of these relations was such that the local party and the doctors of the Centre were unaware of the existence of any link between the local administration and the health centre's involvement in public health programmes. From the point of view of the DDASS, involvement with the health centre was seen as a way of reasserting their influence in the health field, in the face of what they saw as the increasing and unwarranted intervention of the Health Insurance Funds in health policy at the local level.

According to an official at the DDASS, the social security organisations had over a number of years taken more and more initiatives in the field of health policy. In the view of this official, these initiatives had the sole object of restricting health spending and showed that the 'Sécurité Sociale' had little understanding of the concept of 'l'intérêt général'. However, none of the officials claimed that this was government policy, but rather saw it as a result of the influence of the CNPF. Nevertheless, as a member of the local administration pointed out to me, the scope of departmental administrations for taking independent initiatives of this sort was limited. The main role of the DDASS in the department is that of a public health inspectorate and, as such, their ability to influence primary health care provision and the medical profession is limited to the occasional vaccination campaign. The funds available for backing the type of action taken in Grenoble were also limited, so that when a neighbouring socialist municipality came to the DDASS with plans to open a health centre and seeking similar aid, the director felt obliged to recommend against the project as his department would be unable to provide similar assistance.

The delaying tactics employed by the Prefect, the hostility of the medical profession, and the reticence of the health insurance organisation, were all minor obstacles in comparision to the most serious and fundamental problem faced by the Centre. This was that the type of health care provided by the doctors of the 'Centre de Santé de la Villeneuve de Grenoble' was incompatible with the way the health service in France is organised and financed. A basic principle of the Centre was that treatment should be provided free of charge. However, the income of the Centre still depended on the number of 'actes' performed by the medical staff of the Centre. The 'acte' is the administrative

technique used within the system of national tariff agreements to categorise and evaluate medical activity. Its main justification is that it facilitates the work of the Health Insurance Funds at the same time as perpetuating the myth of 'payment à l'acte', one of the principles of 'la médecine libérale' most dear to the medical profession.[3]

Various factors combined to undermine the financial viability of the Centre. Although its main income came from specialist and general practice, the Centre also had its own X-ray and laboratory services. All the services provided by the Centre were free to the consumer, and financed by the Health Insurance Funds in accordance with the value of the respective 'key' letters. However, in accordance with the rules laid down in the 'Convention Nationale' negotiated between the Health Insurance Funds and the medical profession, the value of the key letters for services provided by Health Centres was reduced by 7%. In addition to this the Health Centre received no allowance for the administrative costs of verifying patients' entitlements to health benefits or for the administrative cost of processing claims on the insurance schemes, costs that in normal circumstances would be borne by the Health Insurance Funds. Most importantly, this system of financing penalised the type of health care that the Centre was attempting to provide. Under a fee for service system of payment for health care the rate at which a consultation is charged is FF45 (in 1979), whether that consultation lasts five minutes or half an hour. The fact that doctors at the Centre practiced what they called a 'médecine lente', and that they did not systematically prescribe drugs and laboratory tests, effectively reduced the potential 'income' of the Centre.

In addition, the very raison d'être of the centre was an attempt to

counteract what the founders saw as the tendency of practitioners within the existing system to maximise their income by multiplying the number of medical 'actes' performed. This, they felt, was due not to the particularly avaricious nature of members of the profession but to the logic of the system of financing health care. The result, according to the philosophy of the doctors working at the Centre, was either long hours or a concentration by the practitioner on certain lucrative procedures and high technology medicine. An illustration of the contradiction that existed between the aims of the Centre and the logic of the system is provided by the Centre's X-ray department. X-rays are refunded according to the key letter 'Z' which, for a variety of reasons, is overvalued. The Centre could certainly have resolved its financial problems by making maximum use of the X-ray department and the laboratory, where the same logic applies. But this would have been in total contradiction with the philosophy of the Centre. The Centre's doctors were trying to demedicalise certain health problems, and an important part of this philosophy was to demystify some of the technological appendages of modern medicine. Sacrificing these principles would have made a nonsense of the other practices of the Centre.

The combination of high administrative costs, the style of medicine practiced by the doctors at the Centre, and the rate at which the social security institutions refunded acts performed at the Centre explain the financial difficulties faced by the Centre throughout its existence. This situation was the result not of inefficiency or incompetence, nor was it proof of the unviability of this type of practice as its opponents claimed, but of a system of financing health care adopted many years before, and designed primarily for the convenience of the health insurance organisations. Faced with these difficulties the subsidy provided by

the municipality and the indirect assistance received from the local administrative services of the Ministry of Health were not enough to solve the financial problems of the Centre. Doctors and administrators were forced to become 'income', as opposed to 'cost', conscious, and to limit the provision of certain 'non-productive' activities such as preventive care.

A crisis of a more political nature closed the Centre in 1975. The third party payment agreement which the Centre had negotiated with the health insurance organisations in 1972 was only granted for a period of three years. This system of payment for health care is by law only granted after local practitioners, who have the right of veto, have been consulted. This right of veto stems from Article 18 of the 'Convention Nationale', which was inserted as a concession to the medical profession at the time of the negotiations over the first 'Convention Nationale'. At the time of the creation of the Centre there had been no objection from the medical profession to a third party payment agreement as it was located in a new housing development, with no established surgery in the area likely to be affected. However, there were already certain reservations about the nature of the Centre, as the social security institutions took the unusual step of only granting the agreement for a limited period of three years. At the end of this period it was withdrawn without explanation by the local branch of the social security organisation, the 'Caisse Départementale'.

The 'caisses', the decentralised bodies which collect and distribute contributions and benefits, are administered by a 'Conseil d'Administration' made up of representatives of the beneficiaries and contributors to the insurance scheme. Since the 1967 reform and the introduction

of the system of 'représentation paritaire' the membership of these boards has been divided 50/50 between employers and trade unions, with the employers in the form of the CNPF having a natural majority over the divided unions.

Faced with the threat of closure a campaign of protest was organised by the municipality. The Mayor protested to the Prefect, the Regional Prefect, and the Minister of Health, and appealed for similar protests from fellow Socialist MPs. A defence committee was created which organised demonstration marches and poster campaigns, and in its own turn protested to the various administrative levels. The campaign was successful, as after six months the Social Security Organisation gave in and restored the 'tiers payant'.

It is important to stress here that the third party payment conflict was an entirely local affair. The decision to withdraw this concession was taken by the departmental 'caisse', so too was its reversal. The Government and the Prefect could well ignore the protests of the Mayor, but the local protest movement was more effective. This was aimed specifically at highlighting the role of the local 'patronat' in the decision taken against the Centre, a strategy that played on their sensitivity to publicity over their role in the Social Security Organisations, still an important symbol for the working classes and trade unionists.

Despite having resolved this conflict, the Centre's financial problems remained serious. One administrator admitted that the Centre had only been able to survive by pre-empting the Government in adopting a policy of limiting expenditure to the level of receipts. Doctors' salaries were blocked in 1978, and only increased slightly over the next two years.

Some of the Centre's prevention programmes had to be dropped, as well as planned evaluation studies on the effectiveness of the programmes carried out so far. This left the doctors of the Centre bitter, as they argued that the type of medicine they provided at the Centre actually produced a considerable saving for the Health Insurance Funds.

They pointed out that with a third party payment system the administrative costs of processing claims on the insurance funds were borne by the Centre, where normally these would be the responsibility of the 'caisse', secondly that the expected increase in demand for care resulting from provision of free treatment had not materialised. Statistics collated by the Centre support this claim as they show that the number of X-rays performed per consultation was below the national average as was the number of prescriptions given out, and the rate of hospital admissions. The number of 'arrêts de travail', another significant measurement, remained close to the national average.[4] According to the Health Centre's doctors this was in part a result of their attempts to make their patients more responsible for their own health.

7.iii. **Evaluation of the Medical Practices of the Centre**

One of the chief aims of the Centre was to break the link between the provision of health care, and payment. The supporters of the Centre argued that this system created an unhealthy relationship between the doctor and his patient, discouraged certain sections of the population from visiting the doctor, and encouraged what they called 'fast medicine'. As already pointed out, the Centre was not able to avoid financial considerations entirely, as its income remained dependent on the number of 'actes' performed, but the doctors themselves were salaried, and therefore not influenced by the knowledge that their income depended

on the number of patients they saw. In this situation, they argued, a doctor can afford to spend the time necessary to question patients on their medical, family and social background, to explain their diagnosis, and to suggest means of prevention. The administrative resources of the Centre also enable the doctor to record and file this information in a well organised system. This might seem natural procedure to a British doctor but, as A. & J. Porter noted, it is by no means common in France.[5] None of the above activities are classified as 'actes' and would hence have to be done in the doctor's time and at his expense.

One of the main criticisms of the existing system made by practitioners at the Centre was that French doctors tend to work on their own in private surgeries, or in small group practices. As a result, the general practitioner is isolated from his colleagues, and even more isolated from the specialist on whom he is increasingly dependent. The result is, they claim, that patients are sent on a tour of the surgeries of a number of specialists before they eventually arrive at the right one. They also argued that the fee for service system of payment results in doctors working long hours, with no incentive to take time off to attend refresher courses in order to keep up with the most recent advances in medicine. This problem was recognised by central government, which responded by creating an association to encourage post-graduate training for general practitioners. But, in the view of the supporters of the health centre concept, the impact of this association seems likely to be small as this was too little and too late and it relied on the willingness of doctors to accept either a reduction in their earnings, or to add a few hours to an already long working day. The Centre claimed to provide a solution to this problem. The existence of a multi-disciplinary team enables specialist and general practitioner to work together in close

and continuous cooperation. The role of the specialist at the Centre is not just to supply specialist treatment, but also to educate the general practitioner in the basics of his speciality, enabling him to accurately direct patients to the relevant specialists.[6] The size of the Centre has also enabled the organisation of more civilised working hours. In general the doctors work an 8 hour day. Shifts are arranged to cover weekend and night emergencies, and it is always possible to arrange leave for the attendance of conferences and short courses. The excuse of overwork and lack of time for not being able to keep up with medical developments is no longer valid.

The above could be described as advantages, or economies of scale. They were made possible by the administrative resources of the Centre, and although they contributed to the provision of 'better medicine' they do not represent anything fundamentally new or different. The relationship the doctors claim to have developed with their patients however was something new. The ending of the commercial nature of the medical act was the first step to changing this relationship. The doctor was now no longer dependent on the continued custom of his patient for his income. The patient was no longer buying a 'product'. As expressed by one of the doctors at the Centre, 'nous en avons fini avec les relations obséquieuses' (we have done away with the obsequious nature of relations between doctor and patient).

The doctors of the Centre claimed to have been influenced by the theories of Illich. Thus they sought to demystify their own role, to demedicalise certain problems, and to stress the social context of certain diseases. They met a number of problems in applying this approach, not least of which was that within the existing system it did not make

good financial logic. But on a more theoretical level it was found to be an approach that did not go down too well with the consumer either. Firstly, for a public conditioned to pay for health care, there was bound to be a certain amount of suspicion for anything that was offered free of charge. Secondly, the consumer who traditionally judged the quality of his doctor by the number of items on his prescription or the sophistication of the laboratory tests ordered, did not appreciate one who sent him home with sound advice but empty handed. This was especially true of the working class patients of the Centre who, in addition, had little sympathy with the ideals of the doctors. By contrast the Centre became very successful with the more priviliged and educated sectors of the population. Statistics drawn up at the Centre suggested that this section of the population was more likely to visit the Centre than other groups. One of the doctors of the Centre complained that it was tending to become a meeting place for left wing intellectuals coming to expose their conception of life to their doctor. This suggests that there is some truth in the PCF's taunt that the Centre provided 'bourgeois medicine'.

Nevertheless a number of interesting innovations were introduced in the way in which consultations were conducted. The doctors of the Centre always explained their actions, diagnosis and remedies. The best illustration of this is the way in which the X-ray department of the Centre functioned. The X-ray department is an example of medical technology par excellence. The consumer is in a position of ignorance. Faced with what he assumes is absolute knowledge he becomes part of a mechanical process. At the Centre, in contrast to normal practice, there were always two technicians present, one of whose sole task was to describe the procedures being carried out and the significance of

the result to the patient. All X-rays were noted on the patient's record card to avoid duplication of procedures and unnecessary exposure to X-rays.

In an attempt to demedicalise certain problems and practice preventive medicine, the doctors of the Centre regularly organised what they called 'mini-conseil'. These were meetings with the users of the Centre to discuss common problems identified by the doctors, ranging from medical problems such as the common cold, to such non-medical problems as the disciplining of young children. In the first case the aim was to discuss methods of treatment and prevention. In the second, users were invited to explore the problems themselves, with the object of encouraging the individual to identify and resolve these problems alone. An example of this approach was the poster and pamphlet campaign launched by the Centre on the 'sore back'. This suggested a number of simple rules regarding posture and the lifting of weights which would prevent it occurring. It also suggested that the cause of the pain might by psychological, or connected with working conditions, in which case it advised that the best solution was not necessarily a visit to the doctor, but action to remove the root cause. The doctors of the Centre stressed that, while their intention was to make the individual more responsible for his or her own health, a consultation or visit was never refused.

The Centre also encouraged preventive medicine. There is no 'key letter' for preventive actions recognised by the Social Security Organisations, so that any activity of this kind is not refunded. The Government runs quite extensive prevention programmes aimed at society at large. These include TV advertising campaigns against smoking, alcohol, and accidents at work, which are the products of a strong

tradition of 'public health' programmes run by the administration. Preventive medicine is also provided for pregnant women and for children as part of a broad policy designed to encourage population growth. But there is little sympathy for the type of prevention that involves the general practitioner directly with his patient.[7] An example of the preventive activities of the Centre is the campaign carried out for the detection of breast cancer. A series of meetings were held at the Centre where the techniques of self-examination were explained and demonstrated. Pamphlets were also distributed to the inhabitants of the Centre. The results of the campaign were inconclusive. It produced a dramatic increase in the number of consultations relating to breast cancer, but not in the number of cases confirmed. This example illustrates the weakness of the Centre's case for preventive medicine, given their isolation within a hostile system. The sample was not large enough to provide conclusive proof of the value of their methods, nor did the Centre have the resources to carry out a long term study of the results. Another feature of the type of care provided at the Centre was the important role given to the secretaries and receptionists. They were not only responsible for the normal work of organising doctors' appointments, but also for judging the degree of urgency of a patient's request and, horror of horrors for the medical community, they also prescribed treatment for certain common ailments. The logic behind this was to show the consumer that the doctors do not have the monopoly of medical knowledge, and that others are capable of giving them precise and reliable information on their state of health.

The doctors of the Centre believe that medicine, society and politics cannot be separated, and that medicine is consciously or unconsciously a political act. One of them argued: 'To treat a stomach ulcer, only

seeing it through the lens of a fibroscope, is political in the sense that it is to ignore certain causes of the ulcer'. In addition doctors of the Centre insisted that ill health is partly the result of

> physical and psychic conflict, and rebellion against the imposition of certain family, social, economic and political structures. That it is not the role of the doctor to disguise this behind a convenient medical tag, and that it is false to call a man cured when he is sent back to the rhythm and noise that made him ill in the first place.[8]

These were grand ideals which remain difficult to put into practice. If carried through to their logical conclusion, the doctor should do nothing for a patient apart from explain to him how society is exploiting him and that the only effective prescription is a change in society. In reality the Centre responded to the demands of the consumers and provided treatment and drugs, yet at the same time tried to pass on their message. As one of their number explained:

> Ninety-five per cent of our activity consists in supplying curative medicine which, even though it is in many ways more sympathetic, and even though we try to improve it, remains essentially a patching-up job.

7.iv. **The Centre de Santé and the Political Parties**

From the beginning the Centre had always been closely associated with the political parties of the municipality. One of the most frequent criticisms aimed at the Centre by its critics was that it was a politically inspired and motivated exercise. The Centre was most closely linked to the Parti Socialiste (PS), although it should be noted that few of the doctors working at the Centre were actually members of the Party. The influence of the PS can be seen in the attempts of the participants

to run the Centre in accordance with the principles of 'autogestion'. Thus there was no decision making hierarchy between doctors at the Centre. Decisions were in theory taken collectively. The Centre also tried to abolish the division of labour that exists in most organisations. Doctors were expected to act as secretaries, receptionists, and play-group leaders, when necessary, though it was accepted that the reverse was not possible. An attempt was made to increase 'public participation' in the decision making processes of the Centre too. This has met with little success. The users' committee which was formed only functioned sporadically when the existence of the Centre was threatened.

The flow of influence between the Centre and the PS was not one way, the Centre in its turn influenced the Party's health policy programme. Prior to 1978 health policy was rarely, if ever, raised as an election issue by any of the major political parties. The experience of the Centre provided the PS with the basis of an alternative policy, which was included in their manifesto for the elections for the National Assembly of 1978. Health policy became an issue in French politics for the first time during these elections.[9] The influence of the experience gained with the Centre is even more evident in a recent policy paper of the Socialist Party, which proposes to make the health centre model the basis for its future health policy.[10] Another policy paper of the Party which considered possible reforms of the social security system concluded with the recommendation that the third party payment system be generalised, and that the social security organisations should contribute to the financing of future health centre creations.[11] The 'policy impact' of the Centre, however, will only be measurable at the end of the Socialist Government's term in office.

The Parti Communiste Français (PCF), in contrast to the PS, after initial support, became very critical of the health centre. This may be explained as being the result of 'political jealousy' on seeing one of its own ideas exploited so well by another party. But it was also because the Party had no sympathy for the type of medicine practiced there. The PCF are defenders of 'la médecine libérale' (see chapter four). They have attacked government attempts to cut the cost of the health system, including those aimed at reducing medical incomes. They have strenuously resisted government attempts to reform the social security system. Their prescription for a better health service seems to be 'more consultations, more X-rays, more lab tests, more hospitalisations, and all refunded at the rate od 100%'. The attitude of the PCF is on the face of it not surprising, but can be explained in terms of their role as a professional party of opposition. It is also due to a genuine attachment to and belief in the independence of the Social Security system in whose creation the Party played an important part. The Centre's desire to provide a 'médecine lente', and its attempts to demedicalise certain problems, were dismissed by the Communists as being 'bourgeois medicine, with no relevance to the working man'. During the many struggles of the Centre with the Health Insurance Funds and the medical profession, the PCF gave only token support once it had lost control and withdrawn from the committee set up to establish the Centre.

The political parties of the right were predictably hostile to the Centre and followed closely the line of the medical profession in Grenoble. The Centre was dismissed by them as an electoral stunt of the Socialist Party. The virtues of the existing system were extolled, and the status quo defended. Socialist health policy proposals were portrayed as being

the first steps to a soviet style health system or, almost as bad in the eyes of the French, the British National Health Service.

7.v. Conclusion

The 'Centre de Santé de la Villeneuve de Grenoble' was an experiment affecting a tiny proportion of the French population and, as such, was by no means a threat to the dominance of 'la médecine libérale' but, as the antithesis of the dominant medical ideology, it does act as a mirror reflecting some of the characteristics of that system. La médecine libérale' is a system based on doctors working in private individual practice, isolated from other general practitioners and specialists. The fee for service payment system encourages a multiplication of acts and leaves little place for preventive health care. Poor communications between doctors and specialists, and the long working day, lead to duplication and waste, with an excessive use of technical procedures such as X-rays and laboratory procedures. All these factors add up to escalating health costs which the government has attempted to resolve by appealing to the profession to exercise self-restraint, a solution which has so far met with little success.

The experience of the Centre suggests that Cohen's analysis of the French health system is correct. The system of payment of doctors has created its own logic, which no amount of incremental changes aimed at encouraging greater self-discipline on the part of the profession, or greater restraint on the part of the consumer, is likely to alter.[12] This, as the example of the 'Centre de Santé de la Villeneuve de Grenoble' shows, is not just a convenient system for paying the medical profession, but is the key to primary health care policy, determining both the nature of health care provided and the level of spending on primary health

care. Any policy aimed at changing the one or the other must, of necessity, tackle this issue. The consequences of such a policy in terms of opposition from the profession, and possibly from the general public, explain the reluctance of past and present governments to take such a step.

The case of the 'Centre de Santé de la Villeneuve de Grenoble' throws an interesting light on both the process of policy making and the issue of centre-periphery relations in France. Here it is necessary to refer back to the discussion in chapter one of the debate between Dahl and Bachrach and Baratz on decisions and non-decisions. In Grenoble the differences faced by the health centre were the result not so much of a conscious policy decision in favour of one form of primary health care policy against another, but rather a decision taken many years previously in favour of one system of financing health care against other possibilities. The proponents of the health centre might argue convincingly about the benefits of the type of care provided there, but in so doing they would be missing the point. For the policy makers the essential issue remained how to organise a coherent national system for financing the provision of health care, rather than the type of health care provided at the point of delivery. Therefore, although it might be argued along the same lines as Bachrach and Baratz that this is an example of 'non-decision' in which the proponents of the health centres lacked the political muscle to get their issue onto the political agenda, it might alternatively be seen as an example of how actors within different parts of the policy process perceive issues from different perspectives. In other words, no policy initiatives were taken in favour of the health centres, not because of a powerful alliance of interests which excluded the issue from the policy agenda, although this alliance certainly existed,

but because the prime concern of the policy makers was for the financial coherence of the system rather than for the nature of care provided.

In Grenoble the involvement of the Socialist mayor and municipality were major factors in ensuring the success of the health centre, but in general it is clear that this involvement was an exception to the rule, and that on the whole local political actors have little influence on primary health care policy. The commitment of policy makers to 'la médecine libérale', or more accurately to the system of financing health care that it implied, has to a large extent made the local dimension of the policy process irrelevant. This can be interpreted in two contrasting fashions. The way doctors provide health care, the way this care is consumed by the patient, and the way health care is evaluated is decided in Paris. However, 'la médecine libérale' also means that it is up to the individual doctor to decide where he sets up practice, what he prescribes, and how he treats his patients. The lowest level of decision making is thus that of the 68,000 individual doctors in liberal practice. The policy process may thus be considered at one and the same time as an example of extreme centralisation or, equally justifiably, an example of absolute decentralisation.

Chapter Eight

THE 1970 HOSPITAL LAW
Rational policy making and muddling through

8.i. Introduction

In contrast to the process of policy making for primary health care, the 1970 Hospital Law is an example of what might be called 'heroic' policy making. The law was preceded by a Government commissioned report analysing the existing situation and justifying the proposed reforms which was followed by a debate and voted upon in the National Assembly and the Senate.[1] Its aims were ambitious and clearly stated; to reorganise the entire hospital system. It was described by numerous commentators as being a major event in the history of French hospitals. As a result in this instance, policy can be clearly identified and analysed on the basis of official documents and a law stating government intentions, rather than deduced solely from interpretations of what governments actually do.

In the first section of this chapter the background to the 1970 Hospital Law, the actors involved in the policy process and the policy process itself will be examined. The 1970 Hospital Law is then analysed in detail, and contrasted with the measures that have since been taken to implement the law (chapter six deals specifically with local aspects of the implementation process). In conclusion a number of points will be made about the policy process in relation to this specific policy area, in comparison with policy making in the field of ambulatory medicine, and existing theories on French government and politics.

8.ii. The Background to the 1970 French Hospital Law

Prior to 1970 the concept of a national hospital system did not exist in France. As already noted in chapter two, French hospitals are communal institutions and not part of any wider departmental or regional service coordinated by the Ministry of Health. In addition the French hospital system is divided between public and private sectors, each with its own particular objectives and characteristics. While in the early post-war years there had been little hospital development, in the mid-sixties, by which time the French 'economic miracle' was well under way, the situation had changed and hospital construction was booming. In this context the 1970 Hospital Law might be seen as the predictable response of rational planners to a new situation. Hospitals were being constructed all over the country by both private and public interests, with no central control or planning, leading to duplication and a waste of resources. The 1970 Hospital Law was an attempt to bring order out of this chaos. However, this interpretation is that of the 'armchair analyst' described by Allison, and imposes a rationality on past events by a judicious selection of available evidence.[2] While one of the aims of the Law was certainly to introduce some form of planning to the hospital system, this was part of a far wider reorganisation of the hospital resources, and the process of policy making was at one and the same time more complex and more banal.

The 1970 Hospital Law was the end result of a series of reports commissioned by Robert Boulin soon after he became Minister of Health in early 1970. The author of the report on hospital policy, our concern here, was Roger Grégoire, a 'Conseiller d'Etat' well qualified for the task as he had previously been President of the 'Commission Santé' of the Vth Plan and was an ex-President of the 'Commission Nationale de

l'Hospitalisation' (CNH), a 'quango' responsible for studying hospital construction plans. Of the two dozen reports presented to the new Minister only the one prepared by Grégoire reached the statute books. The important question to answer here, assuming that all government reports are commissioned in response to an identified problem, is why some reports result in concrete policy proposals being put forward and, still more important, why a smaller proportion of these proposals are taken up by government and implemented as policy.

According to Grégoire, the idea of a series of reports on health issues initially came from a junior member of Boulin's 'cabinet', Guy Thuiller. Thuiller, like most of those working in Ministerial cabinets was a member of one of the 'Grandes Ecoles' (in this case the 'Cour des Comptes'), persuaded Yan Gaillard, the director of Boulin's cabinet, who in his turn persuaded the Minister of the need for such a report. This might appear a somewhat casual explanation of the origin of a major reform of the French hospital system. It is nevertheless a plausible scenario. The 'cabinet ministériel' plays a vital role in policy formation in France.[3] The 'cabinet' is a small team personally selected by the Minister to act as his policy 'think tank' and as supervisors of the bureaucracy of the Ministry. These cabinets are staffed mainly by graduates of the 'Grandes Ecoles', who are on the whole generalists rather than specialists. Boulin himself was a technical minister appointed for his administrative abilities rather than for his political affiliations. However, Boulin had no previous experience of health policy. It is thus quite plausible that one of his first actions should have been to commission a report on the French health system. This would enable him firstly to familiarise himself with a new field, and secondly to identify and select his policy priorities.

As the initiator of the idea, Thuiller was given the job of commissioning the authors of the report which was to cover a wide range of aspects of the health system. Thuiller approached Grégoire who he knew from their work together on the 'Commission Santé' of the Vth Plan, and asked him to do a report on the 'humanisation' of public hospitals. Grégoire told me that initially he refused, believing the issue to be unimportant. However, he put forward a counter-proposal which was that he present a report on what he considered the far more fundamental problem of the organisation and administration of the hospital service as a whole. Grégoire's proposal was transmitted by Thuiller to the Minister, who gave the go ahead. The issue of the organisation of the nation's hospital service was of course a topical one. As a man with considerable experience of the hospital service Grégoire was of course fully aware of the many problems in this area under debate, by doctors, hospital administrators and the Insurance Funds managers. The suggested topic for his report was therefore not simply a result of personal whim. 'Humanisation' was the label given to the policy of improving conditions in public hospitals by gradually replacing large communal wards with smaller 4-bed wards and individual rooms which was strongly promoted by S. Weil.

8.iii. **Pour une Politique de la Santé - The Grégoire Report**

In the introduction to his report, Grégoire states his main concern in the form of a question:

> Notre système hospitalier, répond-t-il aux besoins sanitaires et cela de la manière la plus économique et la plus efficace? (And what he identifies as the main problem in his answer) Il est permis d'en douter en raison même de son manque de cohérence.[4]

In his report Grégoire systematically tackles the main issues in hospital policy of the day, analysing the roots of the problem, setting out the possible solutions with their advantages and disadvantages, and recommending what he considers the optimum solution. On the issue of the coexistence of a public and private hospital system, Grégoire concluded that this competition had become an increasingly costly luxury resulting in the inefficient use and duplication of resources. One solution he envisaged was the nationalisation of the hospital sector. He wrote:

> La nationalisation des établissements d'hospitalisation publique réalisée en Grande-Bretagne dans le cadre du service National de Santé a grandement facilité le renouveau de l'appareil hospitalier... (but concluded) Il serait sans doute impossible de réaliser une réforme aussi brutale en France.[5]

Although Grégoire openly admitted to being hostile to the idea that health care might be a source of profit, he argued that 'la seule attitude réaliste consiste à faire en sorte que l'apport de capitaux privés serve au mieux les intérêts sanitaires de la population'.[6]

Given the existing structure of the hospital system Grégoire proposed that in the short term policy makers should seek to coordinate public and private sectors and to make them complementary rather than conflicting parts of the hospital system. In the long term he proposed a process of gradual change based on greater investment in the public sector with the aim of altering, over time, the image of the public hospital, and the attitudes of the general public and of the medical profession towards this sector. In the short term, therefore, Grégoire recommended that the private sector should be encouraged to cooperate with public hospitals. Amongst the measures he recommended to encourage such cooperation were soft loans from the State and the social security

institutions and favourable treatment from the tariff setting councils. However at the same time Grégoire also recommended a number of measures designed to make the private sector less attractive to practitioners and patients alike.

In his report Grégoire also puts forward an explanation for the rapid growth of the private sector since the creation of the Health Insurance Funds. Firstly he argues that as a result of a lack of investment the public sector came to be seen as uncomfortable and old fashioned. Secondly that the growth in demand for hospital care outstripped the growth in capacity of the public sector leaving a gap in the market. Thirdly that the health insurance organisations which at this time were highly decentralised, and which had the right to negotiate independently, often favoured private clinics. According to Grégoire a large number of these agreements were signed, the local insurance funds preferring the private sector as it appeared cheaper, and was also more popular with their subscribers. According to Grégoire the elected members of the Health Insurance Funds saw the health insurance system as an affirmation of the right of all citizens to health care and the abolition of privileges in this sector. To the consumer and the Health Insurance Funds the abolition of privilege meant not the abolition of the private sector, but rather the right for all to enjoy it. This attitude on the part of the health insurance organisations to the private sector led to what Grégoire described as 'une trop grande bienveillance à l'égard d'intérêts privés'.[7] From this Grégoire concluded that the private sector had been built up on public funds, and recommended that in future these should be concentrated on improving the public sector.

After dealing with the relationship between public and private sectors,

Grégoire turned his attention to the internal organisation and administration of the public hospital. According to Grégoire, 'La gestion hospitalière est caractérisée par la multiplicité des centres de décision et par l'absence d'élément coordinateur'. He pointed out that, although the administrative council of the public hospital was theoretically responsible for running the institution, in practice the hospital director, appointed by the State, was the one most directly involved in the day-to-day administration of the hospital. Grégoire argued that the administrative councils were far too politicised but also too large to be an effective executive body, and that the hospital director also lacked the legal authority to fill this role, leaving a decision making vacuum.

This problem was made worse in Grégoire's view by the mass of central government regulations and circulars covering hospital administration. In common with analysts of other policy areas, Grégoire also criticised the degree of centralisation of decision making, claiming that in many cases the requirement to refer decisions to central government for approval was unnecessary.

Grégoire envisaged a number of solutions to the problem of hospital administration. His first proposals concerned the membership and powers of the 'Conseil d'Administration'. Grégoire felt that the increasing role of central government in financing hospital care, and the changed nature of hospital care meant that there remained little logic in the continued close association of hospital and commune. However he also recognized that any proposal to remove the statutory right of mayors to chair the board of administration of the local hospital would be opposed by a powerful alliance of local and national forces, and would hence have little likelihood of being adopted. Instead he sought to water down

the number of 'political' appointees to hospital boards, and to introduce a system whereby the Presidents of the 'Administrative Councils' of the larger departmental and regional hospitals would be elected by the members of these councils. The proposed make up of the new hospital administrative boards are more clearly set out in the table on the following page.

The third salient issue addressed by Grégoire in his report was the role of the medical profession in the public hospital:

> En raison de leur qualification et souvent de leur notoriété personelle, les membres du corps médical exercent indivuellement un pouvoir de fait parallèle et parfois opposé à celui de la direction.[8]

The undue influence of the medical profession is explained by Grégoire as partly the result of tradition, and partly the effect of the principles of 'la médecine libérale'. Curiously, Grégoire did not consider the fact that this is a problem common to most Western health systems despite the different ways in which these are organised.

This separation of powers was for Grégoire the explanation for many of the problems faced by the hospital service. In his report he points out that, although only 20% of the cost of hospital care is directly attributable to the medical decisions of doctors, that at least 65% of the balance is made up of fixed costs that cannot be compressed. Thus he argued that if the evolution of hospital costs is to be controlled the medical profession must of necessity be associated in the decision making process within the hospital organisation.

The solution to this problem proposed by Grégoire was the decentralisation of hospital administration by service, with the head of each

Composition of Hospital Administrative Boards

prop.	Catégories	Etablissement communal	Etablissements départemental	CHR
1/3	Elus locaux	le maire (maire président de droit)	3 conseillers généraux le maire de la ville siège (le président élu)	1 représentant du conseil général de chaque département le maire de la ville siège (président élu)
1/3	Sécurité Sociale	4 représentants	4 représentants	autant de représentants que d'élus locaux
1/3	Autres	2 représentants du personnel (dont un membre du corps médical) 1 médecin de ville 1 personnalité extérieure		2 représentants du personnel (dont un membre du corps médical 1 médecin de ville autant de 'personnalités extérieures' que nécessaires pour compléter l'effectif du troisième tiers

(Source: Pour une Politique de la Santé, Vol.3, p75)

service, a doctor, made responsible for a fixed budget including medical and ancillary expenses. Grégoire argued that this would be the best way of making doctors aware of the broader implications of their decisions. Grégoire's proposals for reforming the relationship between central government and hospital administrators were ambitious and, as he realised, assumed a reorganisation of the central administration as a whole, and more importantly a change in attitudes. He summarised his recommendations as follows:

> Les objectifs doivent être determinés par l'autorité supérieure, mais celle-ci ne saurait intervenir qu'exceptionnellement dans la gestion; c'est par contrôles a posteori qu'elle doit apprécier les résultats.[9]

This statement shows that Grégoire was aware of the wider debate on the distribution of power between central and local government in France that started in the sixties and continued through much of the seventies.[10] However, Grégoire recognised the problems that would face such a reform, thus he pointed out that in order to have 'a posteriori' evaluation by central government of local administration a satisfactory criteria for evaluating the health needs of local population had to be developed, and that in the field of health this was particularly difficult. But Grégoire accepted that such extensive reforms of central government were unlikely. Thus when he recommended replacing standard public accounting methods by budgeting by objectives for the public hospital, he wrote:

> Je n'ignore pas que c'est une réforme de la comptabilité publique qui est ainsi suggérée. Aussi n'ai-je pas d'illusions sur la possibilité de l'entreprendre rapidement.

Another suggestion put forward by Grégoire again shows his

awareness of the wider debate on the French Administration. Grégoire suggested that one way of accelerating the change in attitudes that he believed necessary in the Ministry of Health would be to create an 'Administration de Mission' within the Ministry of Health. The 'Administration de Mission', in contrast to the 'Administration de Gestion', was a new gadget of the Vth Republic designed to overcome the slowness and 'blocages' that existed within the administrative machine of the State.[12] The 'Administration de Mission' consisted of a small independent unit made up of 'Grands Commis de l'Etat' like Grégoire's 'charger d'analyser et de résoudre un problème sous tous ses aspects'. Grégoire, like his contemporaries in the high administration, accepted the popular assumptions about the French central administration, and believed therefore that a simple reform of the structures would create the conditions for rational policy making, whereas the rest of his report serves to highlight the many obstacles, within and without the structures of government, to rational policy making.

Nevertheless Grégoire did show some awareness for the problems facing implementers of policy when, in his conclusion on this section of the report, he wrote:

> La mise en oeuvre de cette réforme nécessite un effort prolongé... Cet effort devra être dirigé... d'une part il s'agit d'une oeuvre de longue haleine... D'autre part cette oeuvre vaudra à ceux qui en assumeront la charge administrative l'hostilité de tous les milieux intéressés: il faudra qu'à l'occasion ils puissent être désavoués par le Ministre; il est donc préférable qu'il ne participent en rien aux responsabilités politiques.[13] (my emphasis)

The most important part of Grégoire's report concentrated on the way in which hospital building projects are initiated and authorised.

In the hospital sector Grégoire reported a 'generally satisfactory situation'. However, he found that hospital resources were unevenly distributed and poorly coordinated. Thus he pointed out that bed population ratios varied from 7.35 per 1000 in Alsace to 3.35 per 1000 in the department of the Nord, and that 10 out of 21 Regions had a bed population ratio below the national average. He also found that many of the beds in the public sector were in old fashioned and delapidated communal wards, which could be modernised in some cases, but in others required complete rebuilding. In addition he discovered that there was no coordination between public and private sectors. Although he found a high proportion of private beds in some Regions where there were few public beds (Aquitaine, Bretagne, Lorraine). He also found a high density of private beds in well equipped Regions like Paris and the Languedoc-Roussillon, and the opposite in poorly equipped Regions like the Nord and Picardie.[14]

This uneven distribution of hospital beds and equipment, and the absence of coordination between public and private sectors was, in Grégoire's view, a result of the way in which hospital construction was organised and financed. This system meant that in the public sector the communal status of the hospital put the initiative for construction with the mayor of the commune. Finance for building hospitals was available from a number of different sources. Central government normally provided up to 30% of the costs, the social security institutions another 30%, the remaining 30% was financed by the commune usually through low interest loans from one of a variety of 'caisses' set up by central government to finance local government expenditure. In other words, although the State directly and indirectly financed up to 60% of public construction costs, it nevertheless could not decide when and

where to build a hospital, but only respond positively or negatively to local initiatives. In addition he found that proposals for public and private hospital projects were processed through different channels. The National Plans in recent years have indicated areas where hospital construction should be a priority. But these plans only provided vague guidelines which set out hospital needs, and in no way guaranteed that funds would be available for construction projects. As a result he found that hospital building projects could be given the green light despite the fact that they were not included in the plan, and vice versa...[15]

In the private sector the initiative for hospital construction comes from individual entrepeneurs. Until 1968 the only restrictions on this sector were government regulations on hygiene and safety, and the qualifications of the medical team. After 1968 and the introduction of tighter controls coordination between the two sectors remained poor as the responsibility for authorising construction in the two sectors remained separate. The first lesson drawn by Grégoire from his analysis of existing resources was the absence of up-to-date and accurate figures on the subject. He found that the most recent statistics from the Ministry of Health related to 1964, and that the statistics on the private sector were incomplete and inaccurate. His second observation was that the method of measuring hospital resources was far from satisfactory.

Hospital resources in France, as in most countries, have traditionally been evaluated in terms of bed numbers. Grégoire argued that this method was misleading on a number of counts. Firstly he pointed out that there is little in common between a bed in a long stay convalescent hospital and a bed in a post operative ward. Each has different implications in terms of finance, medical staff and technology. Secondly he

argued that the existence of a hospital bed does not necessarily mean that it can be used. Other factors such as trained staff and medical equipment must be considered before that bed can be considered as part of the supply of national hospital resources. For these reasons Grégoire argued that the concept of 'beds' had to be replaced by another measure designed to show hospital resources more accurately and in greater detail. He recognised that this would be a difficult task but proposed a new system of evaluating resources which would include medical equipment and would differentiate between the uses to which hospital beds are put.

To achieve this end Grégoire proposed the creation of what he called the 'Carte Sanitaire' or Health Map, a multipurpose instrument designed to improve the information available to decision makers, to evaluate the health needs of the population and to control the future development of the hospital system. Grégoire defined the 'Carte Sanitaire' as follows:

> Il s'agit non pas d'un document descriptif, mais d'un document prospectif. Il doit indiquer les installations qu'il faut améliorer, créer ou supprimer en raison de la situation présente, et des perspectives d'avenir. En d'autres termes il doit donner l'image d'un équipement complet et rationnel.[16]

In this system the concept of beds, while still retained, is given reduced importance, and greater emphasis placed on medical equipment. Where the concept of beds is used, it is done so only in conjunction with medical disciplines.

An integral part of this Health Map was an evaluation of the 'health needs' of the population. Grégoire proposed that the 'health needs' of the population should be evaluated by local administrative services

along guidelines laid down by central government. In this way a 'health map', reflecting the specific needs of each administrative area, would be drawn up. This information would then be used by the national planners as the basis for allocating finance for hospital construction, and by the Prefects and services of the Minister of Health as the criteria for authorising hospital construction projects. As a guard against maximalist demands from local actors, the 'health needs' estimates would be assessed by newly created National and Regional commissions which Grégoire recommended should contain representatives of the Ministry of Health, hospital doctors, general practitioners, and the health insurance organisations. In his report Grégoire specifically recommended that organised representatives of the public and private sectors be excluded from these commissions, arguing that no matter how worthy their intentions might be, their professional interests would prevail.[17]

Once completed the 'Carte Sanitaire' was to be the basis on which all decisions on hospital construction were to be taken. Although the initiative to build a hospital would remain with the local community, finance for projects would only be available for those projects which fulfill 'needs' as set out by the 'Carte Sanitaire', and constructions permits would only be granted on similar criteria. Grégoire believed that this would enable government to develop a rational long term policy for hospital resources. In the private sector, the initiative would also remain with the private entrepeneur, but Grégoire recommended that in order to emphasise the priority given to the public sector the Minister be authorised a period of grace of six months during which to seek to encourage a similar public project. However, in a move designed to simplify administrative procedures, Grégoire argued that an authorisation to construct a private clinic should automatically admit

that clinic to the health insurance system. This meant that the promoters of the clinic would not have to reapply to the Health Insurance Funds for recognition.

Finally Grégoire looked at the system of tariffication in the public and private sectors. Although Grégoire accepted many of the criticisms of the system of hospital tariffication current at the time of his report, he did not recommend any major reforms. Again Grégoire reflected current thinking on this issue. He accepted and repeated many of the criticisms of the system of tariffication based on an 'aggregate daily cost' ('prix de journée'); that it was a disincentive to reducing hospital stays, and that it made realistic budgeting and cost control difficult, but in this case he concluded that a reform of the system of financing would be unlikely to produce any major benefits. He limited himself here to proposing the introduction of a 'forfait hospitalier', in other words a contribution by the patient to cover 'hotel' costs as a way of discouraging overlong hospital stays. In this Grégoire was adopting an idea which had already been mooted by the CNPF on a number of occasions.

8.iv. **From Project to Policy**

Government commissioned reports are by no means uncommon. They are usually well informed, well argued and generally propose measures that might be taken to resolve the problem under consideration.[18] But what distinguishes a report that is left to gather dust on a Ministerial shelf or in the library of the 'Documentation Française' from one that is turned into a major policy reform project? In the case of Grégoire's report, it was partly a question of personality and partly a question of chance. Grégoire was recruited to produce the report as a result

of the well known links between members of the 'Grands Corps', but it is also significant that he imposed a subject of his own choice on the Ministry. He also produced the report in his own way. The working group that he selected contrasts markedly with the working groups of the fourteen other reports which were commissioned at the same time. Grégoire enlisted the aid of six advisors - two members of the 'Cour des Comptes', one 'Conseiller d'Etat', one 'Inspecteur Général des Affaires Sanitaires et Sociale', the 'Rapporteur' from the 'Commission Santé' of the Vth Plan, and two doctors. The working groups of the other reports tended to be much larger, and were dominated by medical men. An extreme example was the working group on 'Rheumatology' which had thirty-nine members and included representatives from all hospitals with a service specialising in rheumatology. Unlike most of the authors involved, Grégoire had no vested interest in the hospital system. Thus Grégoire and his working group could lay claim to a certain degree of impartiality and objectivity. The dominant role of members of the 'Grands Corps' within the group also meant that the final report was couched in language that would be familiar to its readers, and argued on grounds that would be equally appreciated.

But there was also an element of chance involved in the process by which the report became law. Grégoire explained to me that a few weeks before his report was due to be presented, he caught a heavy cold and was forced to stay at home for a week. He spent this time preparing an 'avant projet de loi' on the basis of the conclusions contained in his report, which he hoped would enhance the chances of his recommendations being acted on. This proposed law was attached as an annexe to the report he eventually submitted to the Minister of Health. Again according to Grégoire, three weeks later he received a telephone call

from the Minister inviting him to attend a series of meetings with the members of his cabinet to brush up his draft legislation so that it could be submitted to Parliament. Grégoire explained that the Minister had submitted his report to his civil servants for their analysis and recommendations, but had had no reaction. He therefore proposed to go ahead and use Grégoire's proposals as the basis for a new hospital policy. This is of course Grégoire's own version of the events, given to me during a formal interview at the 'Conseil d'Etat', and it might well be that he has been tempted to exaggerate his own importance to the process. However, if one compares the 'projet de loi' submitted to the National Assembly for debate one finds that it is almost identical to the 'avant projet de loi' drafted by Grégoire and included as appendix to his report.

The above description of the various stages of the development of the 1970 Hospital Law tends to support the thesis that policy innovation in France is the product of a small group of individuals who are able to communicate across the otherwise hermetic barriers of the traditional administration as a result of their membership of certain corps, a common ethos, and their reputation.[19] One result of this is the remarkable similarity that exists between the proposals for reforming the hospital system put forward by Grégoire, and the certain ideas current among the administrative élite at this time on the problems of the French administrative system and their solutions. Thus Grégoire's suggestion that a posteriori control of hospital administration should be introduced draws on the concurrent debate on the way in which central government should supervise local authorities, and his proposal that 'syndicats' be formed by neighbouring hospitals is clearly mirrored by the 1964 reform of local government which set up machinery for the formation of similar syndicates which had the ultimate objective of reducing the

number of small unviable communes through fusions. Grégoire's aim was to encourage small local hospitals to form larger more viable units.

In this sense it can be argued that the policy making process in this area supports existing theories about the importance of the 'Grands Corps', the influence of their brand of rationality, and the 'lines of communication' between the members of these corps that enable them to exert their influence. However, it may also be argued that a crucial factor in the law reaching the statute book was the personality of Grégoire and his desire to reform the existing organisation of the hospital system. Like the introduction of hospital planning in Britain's National Health Service in the sixties, hospital policy in France owed something to the right persons being in the right place at the right time.[20]

In this light it may be argued that while the approach adopted by Grégoire in his report was a model of rationality, the policy process itself can by no means be described as rational in the strict sense. The 1970 Hospital Law was not the product of a Minister of Health anxious to solve a perceived policy problem but rather the result of the arrival in office of a new Minister without a health policy. Thus the initial motivation was not the search for a rational policy in response to an identified problem, but the search for any policy.

8.v. **The National Assembly**

One of the reasons for which the 1970 Hospital Law is remarkable is that unlike most previous reforms of the hospital system it was debated by the National Assembly. The significance of the event was apparently not appreciated at the time as few 'députés' bothered to take part in discussions[21]. Nevertheless a number of amendments were adopted

before the Government used the block vote procedure, and the Bill became law.

The National Assembly is generally regarded as little more than a rubber stamp for decisions taken by the Government.[22] However, in the case of the 1970 Hospital Law it appears that the Assembly played quite an active and significant role. In his report Grégoire had argued that given the existing organisation of the hospital system, the private sector should be accepted as an essential and integral part of the health services of the nation. However, he made it clear that while the private sector could not be ignored, he regarded it as a necessary but barely tolerable evil, and a number of his policy recommendations constituted 'positive discrimination' in favour of the public sector.

The pragmatism shown by Grégoire in accepting the private sector may have been salutory, but it was not enough to satisfy the deputies of the majority in the Assembly who suspected that the real aim of the policy was to gradually eliminate the private sector. As a result an amendment was introduced by a deputy from the majority, and accepted by the Government which inserted the following new preamble to the text of the Law:

> Le droit du malade au libre choix de son praticien et de son établisment de soin est un des principes fondamentaux de notre législation sanitaire... La protection sanitaire du pays est assurée par les... établissements de soin, publics et privés, qu'ils participent ou non au fonctionnement du service public hospitalier institué par la presente loi.[23]

This apparently insignificant amendment has been cited on a number of occasions by private promoters contesting Ministerial or Prefectoral

decisions. Their argument has been that the law guarantees the individual the right to choose between public and private sectors, and that therefore if no private clinic exists in an area, a request to construct a private clinic cannot be refused even if the 'Carte Sanitaire' shows that the public sector meets all identified 'needs' of the population of that area.[24]

The attitude of the Deputies of the majority was encapsulated in a statement from the 'Rapporteur' on the law in the Senate. He declared:

> A ceux qui se réclament d'un service national de la santé, elle, (la Commission Sénatoriale des Affaires Sociales) dit non, devant les conséquences désastreuses pour les malades qui ne sont plus que des matricules aiguillés comme avec un dispatching sur tel ou tel praticien du secteur.[25]

8.v. From Policy to Policy Implementation: la Loi Hospitalière de 1970

In his report Grégoire put forward a large number of proposals, but not all of these were included in the final draft of the 1970 Hospital Law. Some were discarded by Grégoire himself as being impractical, others were removed by the Minister of Health, and the Assembly, as discussed above, changed the emphasis of the original draft. Nevertheless commentators at the time recognised the importance of the reforms that were proposed. According to François Villey, the law was ambitious as it implied the 'reorganisation of the entire French hospital system'.[26]

The Law can be broken down into four main sections, each dealing with different objectives. The first section deals with coordination and includes a variety of measures aimed at improving the degree of cooperation between public and private sectors, and also the cooperation

between hospitals in the public sector. The second group of proposals deals mainly with the reclassification of hospitals according to their size and function. The third and most important set of proposals were those dealing with the 'Carte Sanitaire' , or the introduction of a new system for planning the growth of the hospital system. Finally a fourth set of measures dealt with the internal administration of public hospitals.

This overview of the main areas affected by the 'Loi Hospitalière' gives a good indication of its ambitious scope. It was an attempt at a complete reorganisation of the French hospital system. However, the Law was a 'Loi Cadre', meaning that many of the objectives were in the form of statements of intent, which depended on government issuing decrees at a later date, setting out how these objectives were to be achieved.

8.vi. **Coordination**

As a first step to improve the coordination of the hospital services of the country a new concept, that of the 'Service Public Hospitalier' (SPH) was introduced. The SPH covered both public and private hospitals, but in order to belong to the SPH private clinics had to conform to certain requirements. These were that they treat all person in need without discrimination, that they remain open twenty-four hours a day, and that they contribute to medical research and training. In return these hospitals would enjoy the same status as hospitals in the public sector. As a result it was mainly the private non-profit making sector that took advantage of this system, while the extra costs and the limited benefits meant that for-profit private clinics remained resolutely outside the SPH.

In related proposals to encourage inter-hospital cooperation and to make the notion of a public hospital service a reality a number of administrative bodies were created. At the regional level the 'Groupement Interhospitalier' (GIH), made up of all the hospitals belonging to the SPH in one Region, was created. The GIH is a consultative council made up of the representatives of all the major institutions, which discusses and makes recommendations on problems common to the hospitals of the region. At a lower level the Law made provision for the creation of 'Syndicats Interhospitaliers'. These are formed at the request of at least two hospitals in a sector and run by an administrative council with its own budget, made up of representatives of the member institutions with an elected president. The function of such a 'syndicat' is to provide common services such as laundry, staff and computerisation to neighbouring hospitals.

8.vii. **Classification**

The new system of classifying public hospitals was designed to simplify and clarify the status of public hospitals. The system of classifying public hospitals prior to 1970 included at least five different categories and ranged from the highly sophisticated regional hospital to the old-age home. In the new system a distinction was drawn between institutions serving different functions. The 'Centre Hospitalier' provides general and specialised medicine. The 'Centre de Cure, Convalescence et de Réadaptation' provides medium term treatment. 'Centres Hospitaliers' are in turn classified in terms of their size, medical sophistication, and the population they serve. The 'Centres Hospitaliers Régionaux' and the 'Centres Hospitaliers Universitaires' (only one CHR is not also a CHU) are the large regional hospitals which provide specialist care and medical training. 'Centres Hospitaliers' serve a smaller population and

provide more basic health care facilities. The 'Hospitaux Rureaux', the smallest institutions regarded as being particularly suited to providing the simplest medical care to rural and underpopulated areas, but too small to be viable as independent units, were 'decategorised', as it was the intention that they be transformed into antenna of larger 'Centres Hospitaliers'. The problem of the long stay hospitals was however ignored by the 1970 Hospital Law. The 'Hospices', which under the previous system catered for the terminally ill and the elderly were no longer included in the categorisation of hospitals. The explanation for this was that the terminally ill were seen as a separate problem linked with the wider issue of care and would become the responsibility of specialised hospitals, and that care for the elderly should likewise be treated as separate and distinct.

8.viii. **The Carte Sanitaire**

The lynchpin of the 1970 Hospital Law was the 'Carte Sanitaire', which was created as a means to control, harmonise and plan the future growth of the hospital system. The 'Carte Sanitaire', according to Article 44 of the 1970 Law,

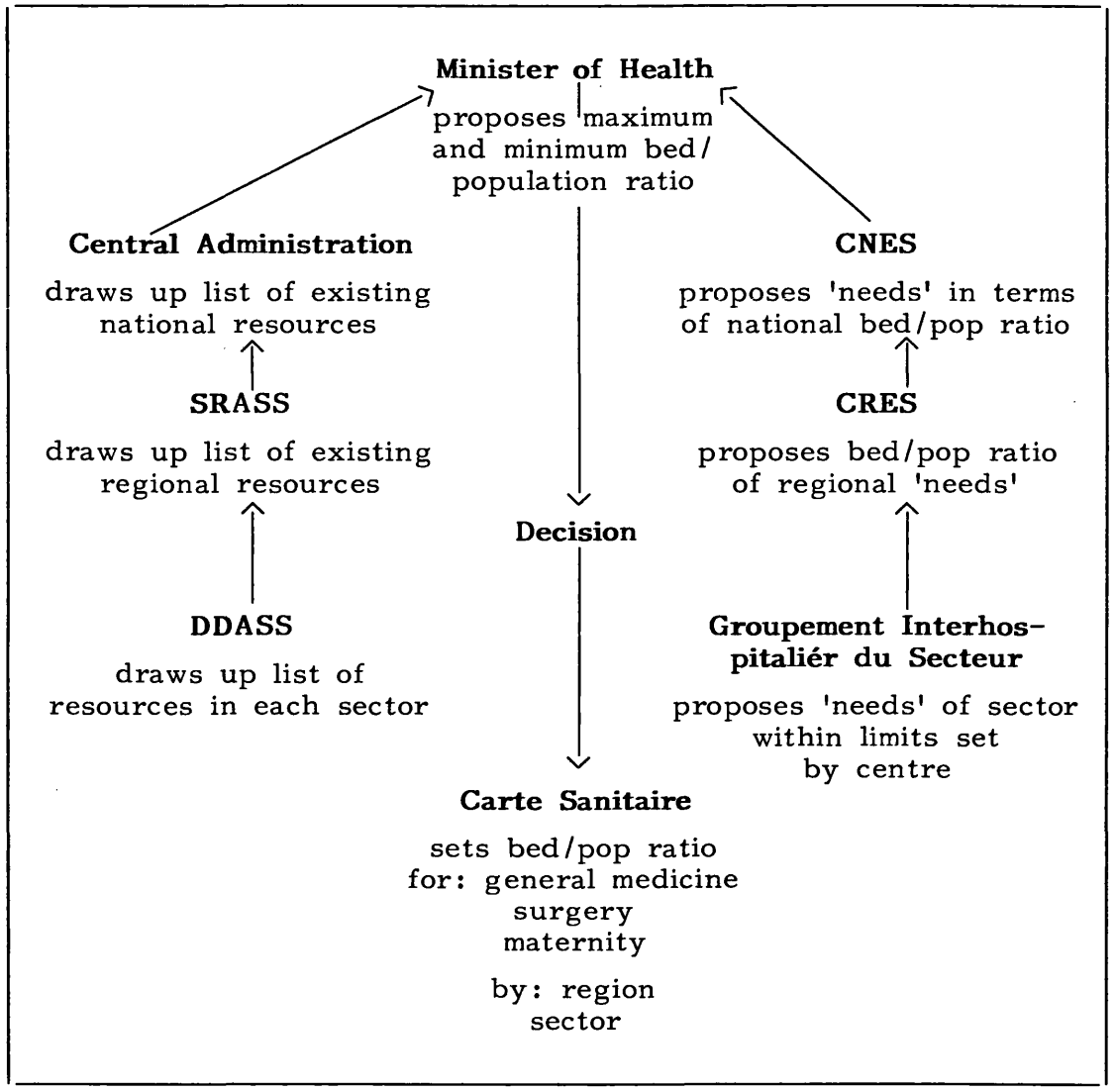
> determines, after taking into account the importance and the quality of existing hospital resources, public and private, as well as demographic trends and advances in medical technology, the health needs of the population.

This means that the 'health map' is made up of two distinct parts. Firstly a survey of existing hospital resources, and secondly an estimate of resources needed to meet the demand for hospital care (i.e. the health needs of the population). The health map itself is made up of 21 regions, and 284 'secteurs'. The basic unit, the sector, covers a population

of between 30 to 50 thousand inhabitants. Resources are measured in terms of beds, but also a new concept, the 'plateau technique', representing the medical equipment and staff required to meet different levels of health needs. The health region has the same boundaries as the administrative Region, and again a minimum 'plateau technique' is defined, this time including more complicated medical procedures and specialised treatment. The 'Carte Sanitaire' also applies therefore to medical equipment. The Conseil d'Etat is reponsible for establishing the list of medical equipment that falls within the scope of the health map. To assist the medical profession in drawing up the 'Carte Sanitaire', a 'Commission Nationale de l'Equipement Sanitaire' (CNES) and, in each region, a 'Commission Régionale de l'Equipement Sanitaire' (CRES), were created.

The final draft of the 'Carte Sanitaire' and any subsequent alterations are published by decree by the Minister of Health after consulting the CNES. The CNES thus has an important role in influencing hospital policy decisions. However the 'Commission Nationale de l'Hospitalisation' (CNH), not the CNES, is consulted by the Ministry when hospital building projects are put before it. So although the CNES draws up the 'Carte Sanitaire' which determines the hospital needs of the country, the CNH advises the Ministry on which hospitals to build and where. In other words two distinct channels of decision making were created by the 1970 Hospital Law - the first for drawing up the 'Carte', and the second for processing decisions on hospital building projects (these decision making processes are set out in diagrammatic form on the following page). It can be seen that under this system all hospital construction, as well as the introduction of expensive equipment in both public and private sectors should be determined on the same criteria. Although decision

Diagram of Decision Making Processes



making is in a sense decentralised it remains controlled by strict norms set out in the 'Carte Sanitaire', which of course is decided by central government. Thus a Prefect's decision on a request for a construction permit from a private promoter becomes a purely technical matter. If the estimate of the hospital needs for the sector is in excess of the existing resources, authorisation must be granted. If authorisation is refused it must be justified in terms of the 'Carte Sanitaire'. Private promoters have the right to challenge decisions of the Prefect in the Administrative Courts and, if satisfaction is not obtained, appeal to the 'Conseil d'Etat. The health map may be revised at any moment by

the Minister, and is in any case completely revised every five years at the same time as the national plan.

8.ix. **Administration**

Finally the 1970 Hospital Law attempted to improve the internal administrative organisation of public hospitals. While the status of hospitals as 'établissement public' attached to a municipality, and thus part of local government, remained unchanged, the balance of power within the administrative councils of hospitals was changed. The number of government appointed members was increased, as was the representation of the medical profession. Since the 1958 hospital reform hospitals have been administered by a deliberative body, the 'Commission Administrative' presided by the mayor of the commune in which the hospital is located, and an executive body, the hospital director and his staff. This is the traditional structure of the administration of French hospitals which has remained the same since the 'Loi du 16 vendemaire de l'an V' gave hospitals the status of communal establishments.[27] The 1970 Hospital Law did not radically change these arrangements, but juggled with the responsibilities of the director and the renamed 'Conseil d'Administration'. According to the 'Code Sanitaire' the administrative rule book, the 'Conseil d'Administration' prior to 1970, 'règle... les affaires des hôpitaux et hospices'. In other words it is responsible for all hospital matters. Its decisions are executed by the director. After the 1970 Hospital Law the new 'Conseil d'Administration' had its responsibilities limited to agreeing the budget, yearly accounts, the opening or extension of new services, the raising of loans, the purchase of equipment, and participation in a hospital syndicate. The Director remained responsible for implementing the decisions of the administrative council, but was also given full responsibility for the day-to-day running

of the hospital, and for all decisions not attributed to the administrative council.

The membership of the Administrative Councils remained unchanged. The 'Association des Maires de France' made it known to the Minister of Health that they would be hostile to any reform that would remove the presidency of the council from the Mayor. The Deputies also made it clear that they were equally hostile to the reduction of the proportion of locally elected officials on the council.[28] Thus the Mayor remained president by right of the administrative council of the hospital in his commune. However the Minister of Health was given considerable discretion in determining the balance of elected representatives to government nominees on the new councils. The new 'Conseil d'Administration' is made up of representatives from the communes, the health insurance funds, the medical profession, and a number of individuals known 'pour leur travaux sur les problèmes hospitaliéres ou leur attachement à la cause hospitaliére', who are named by the Prefect. The exact numbers depend on the size of the hospital. As Grégoire recommended, the non-medical staff were given representation on the council, but contrary to his recommendations, their influence was increased by making the President of the Consultative Medical Committee, a member of the council by right.

A discussion of a number of possible measures to improve the system of financing hospital care can also be found in the Grégoire report. However, the 1970 Hospital Law was vague on this subject. Article 52 of the Law states 'Une réforme de la tarification des soins dispensés dans les établissements devra intervenir dans un délai d'un an à dater de la promulgation de la présente loi'. The nature this reform should

take is indicated by the law which suggests a new system which would distinguish between the different services provided by the hospital, such as costly drugs, medical procedures, and accommodation. However, no comprehensive plan for an alternative system of tariffication to replace the existing system was proposed. Despite this recommendation no progress in implementing this measure had been made up until 1981.

8.x. From Policy to Policy Implementation

The main characteristic of the process of implementing the 1970 Hospital Law is the separation that existed between the conceptual and administrative functions in French government, and the different importance attached to each. The author of the Hospital Law was a 'Conseiller d'Etat' recruited by a colleague serving in a ministerial cabinet. The working party that assisted him was dominated by members of the 'Grand Corps'. These are the 'agents du changement' described by Hayward, in an administration otherwise hidebound by rules and regulations, poor communication, and interdepartmental rivalry.[29]

However, once the law had been drafted and passed by Parliament, the responsibility for its implementation was passed to the civil servants at the Ministry of Health. Thus the Law became separated from its context (the Grégoire report). Those responsible for the implementation of the law had different objectives, priorities and values, and were working within very different constraints. They were not only responsible for implementing the proposals of the Law, but also for the routine administration of the Ministry of Health. They were possibly also not a little hostile to the Law from the start, given that it came from outside the Ministry, and that it added to an already heavy workload

in what was a notoriously understaffed Ministry.[30] It is not surprising then that the implementers lost sight of the long term proposals, and the spirit of the Law, and only conformed to the letter of the text passed by the National Assembly.

As pointed out earlier, the 'Ministère de la Santé' is low down the hierarchy of Ministries in France as in other countries, and as such gets short shrift in negotiations with the Ministry of Finance for credits and extra staff. It also has difficulty as already noted in attracting recruits from the prestigious 'Grandes Ecoles'. However, even within the Ministry there is is a separation between the straight administrative functions and the more glamorous 'think tanks' and 'inspectorats'. Thus Charbonneau argues that in the Ministry of Health as in other Ministries, graduates from the ENA and other 'Grandes Ecoles' tend to go straight to the top of the administration to perform policy making or policy review functions in various commissions and 'inspectorats', like the Inspection Générale des Affaires Sanitaires et Sociale', rather than into the more practical day-to-day administrative services which consequently lack quality administrators.[31] A review of the senior posts in the Ministry of Health confirms at least one aspect of this argument. These posts are filled by 'Inspecteurs des Finances', members of the 'Cour des Comptes', and the 'Conseil d'Etat'. Thus the strength of the 'Grand Corps' system, so useful in forming links between the different parts of the policy formulation process is also to a certain extent its weakness, as these links do not extend to the lower echelons of the administration responsible for policy implementation.

One criteria for judging an organisation, administrative or otherwise, is its ability to learn from past experience and avoid mistakes.[32] This

may be a somewhat unrealistic concept, as it confers semi-human characteristics on large complex organisations, but it is in any case a test that the French administrative system does not pass.

The 1970 Hospital Law can be interpreted as the Ministry of Health following an already well trodden path. During the sixties a number of reforms reorganising local government and administration were introduced.[33] These were characterised by an attempt to rationalise and improve the efficiency of local government by encouraging mergers between the small communes and the sharing of certain services. Like the 1970 Hospital Law these were extremely rational proposals, as the provision of independent services for each commune was wasteful, and a large number of these communes were too small to make economic use of an independent service. The variety of measures proposed to encourage municipal cooperation ranged from the loose association between communes for the provision of a single service, to the fusion of one or more neighbouring communes. Inspite of the laudable aims of the central policy makers, local politicians interpreted the reforms as another attempt by central government to reduce their powers, even if, like the king visited by St Exuperry's Little Prince, those powers were increasingly meaningless. Thus the implementation of this reform was resisted strongly by local forces.

The various forms of 'syndicats' and associations suggested by the 1970 Hospital Law were inspired by the same logic. A desire to increase the efficiency of small hospitals, and to break down the isolation of individual institutions with the view to eventually transforming a number of them into one larger more viable hospital. The results of this policy have been equally disappointing. The 'Conseils Interhospitaliers' which

were conceived to improve communication between hospitals in a region or sector are seen by the participants as an extra administrative procedure with little value. A number of sectoral 'Conseils' have regularly cancelled their meetings. The 'Syndicats Interhospitaliers', associations of neighbouring hospitals to provide common services, were slow to get off the ground. In a ten years period from 1970 only thirteen 'syndicats' were created. Six of these involved the provision of a common laundry service. Three involved the setting up of a nursing school, a staff nursery, and a training centre. The remaining four 'syndicats' were established in the Côte d'Azur and the Ile de France Regions, and involved the setting up of a computer centre, an administrative and staff training school, a regional organisation study group, and the ubiquitous laundry service.[34]

These modest results in many ways reflect the results of earlier attempts made by central government to reform and simplify the structure of French local administration, and can be explained in similar terms. While the Mayor remained the President of the Board of Administration, and the hospitals remained municipal institutions, it was always likely that any reform which sought to reduce the influence of the Mayor, while at the same time depending on the cooperation of Mayors for its successful implementation, was bound to face difficulties. In addition there were certain practical problems. In some cases the 'sector' was found to be too small a unit on which to base any kind of meaningful and economic common hospital service. The Region in most cases was too large. The administrative boards of some of the 'Regional Syndicats' that were established had between 200 and 300 members, making decision making virtually impossible.

The measures designed to encourage a greater cooperation between the public and private sectors have met with varying degrees of success. In the first place it took six years to determine the arrangements for associating the non-profit making private sector hospitals with the SPH. Since 1977, 419 of these hospitals, representing more than 65,000 beds, or over 50% of hospitals and 75% of the total capacity of this sector, now participate in the SPH.[35] This high level of participation is explained by the fact that the non-profit making sector has traditionally played a very similar role to that of the public sector, with certain hospitals like the Hospital St. Joseph in Paris, which was a de facto public service, long before the 1970 Law. The advantages of participating in the SPH considerably outweighed the disadvantages for the non-profit making private hospitals.

The 'contrat de concessions' designed to associate the private profit making sector with the SPH have been less successful. By mid 1977 only seven contracts had been signed, four involving a complete institution, and three involving specific services. The low level of participation here is explained by a number of factors. The form of the 'contrat' was not particularly advantageous for the private clinic, with no obligation on the State to renew the contract as it expired. But probably the most important reason was the hostility to this form of cooperation from within the administration itself and the opposition of hospital administrators as expressed through the 'Fédération Hospitalière de France' (FHF). The more flexible 'contrat d'association' has been equally unsuccessful with only fourteen contracts signed for the same reasons.

Through the creation of a number of new consultative bodies that altered the balance of power between the hospital director and the

administrative council, the 1970 Hospital Law sought to foster a greater degree of cooperation between the various professional groups within the hospital, and to encourage more efficient hospital management by reinforcing the authority of the hospital director. In Grégoire's original proposals this was only the first step to be followed by other reforms changing the nature of State supervision, and increasing the role of doctors in the administration of the hospital. A number of the decrees and regulations changing the role of the hospital director have in fact been issued, and the new consultative bodies created, but the tutellary role of the State over recent years has if anything increased, despite the theoretical commitment to decentralisation contained within the 1970 Hospital Law. Thus, Fournière and Questieux write, 'Il n'est pas de tutelle plus pessante que c'elle qui s'exèrce sur l'hôpital publique'.[36] Grégoire's proposals for an a posteriori supervision of hospital administration have not been followed. The role and power of the hospital director have certainly been increased at the same time as that of the Conseil d'Administration has been limited, but the director is still uneasily poised between the Mayor and the Minister of Health.

Hospital doctors are now consulted more frequently and on a wider range of issues, but they have not been associated in the administration of the hospital to the extent recommended by Grégoire. This illustrates a problem faced by health policy makers in a number of countries. It is difficult if not impossible to regulate a profession that is, both by virtue of tradition and by nature, strongly attached to its independence. Doctors cannot be forced to take a greater part in the administration of hospitals, but at the same time they are not prepared to let administrative requirements impinge on their independence.

Grégoire devoted considerable space in his report to analysing the system of tariffication in public hospitals and suggesting possible reforms. Ten years after, the 'prix de journée' remains the basis for calculating hospital tariffs. In 1978, an experiment with two alternative tariff systems was started in five hospitals following the lengthy debate that raged over the pros and cons of the existing system. However, by the end of the decade a final decision had not been taken as to which if either alternative to adopt.

8.xi. **Implementation of the Carte Sanitaire**

The key proposal of the 1970 Hospital Law was the introduction of the 'Carte Sanitaire' as a means of gathering information on existing hospital resources, and for allocating resources for future developments. Both the Minister of Health and outside analysts have stressed the importance of the 'Carte', and a considerable amount of time and energy has been devoted to setting it up.[37] In theory the health map is an admirably rational and simple aid to decision making, and in many ways typical of French policy making. All decisions on the construction of hospitals, and the purchase of equipment are subject to the 'health map'. The Minister of Health and the Prefect who are responsible respectively for decisions relating to large and costly projects in the public and private sector, and for decisions in both sectors involving smaller scale projects, are faced with a simple mathematical problem. Needs, as determined by the 'Carte', minus existing and authorised resources. If the result is positive, the project may be authorised, if negative, it must be refused.

The 'Carte' encapsulates many of the principles of French central administration. Firstly it codified the decision making procedure. The

'Carte' set down a number of steps which must be followed in all cases. Secondly it depersonalised the decision making process. Decisions had to be taken on the basis of certain pre-set objective norms rather than on the basis of subjective or political criteria. Thirdly it rationalised decision making and introduced a mechanism for planning future hospital policy. Finally it reconciled the two meanings of the principle of 'égalité'. In the first place all decisions were taken in the same way, and different interests were treated in a uniform manner. Secondly the 'Carte', through its measurement of 'health needs', theoretically identified those regions which were underprovided for and allows these to receive special treatment.

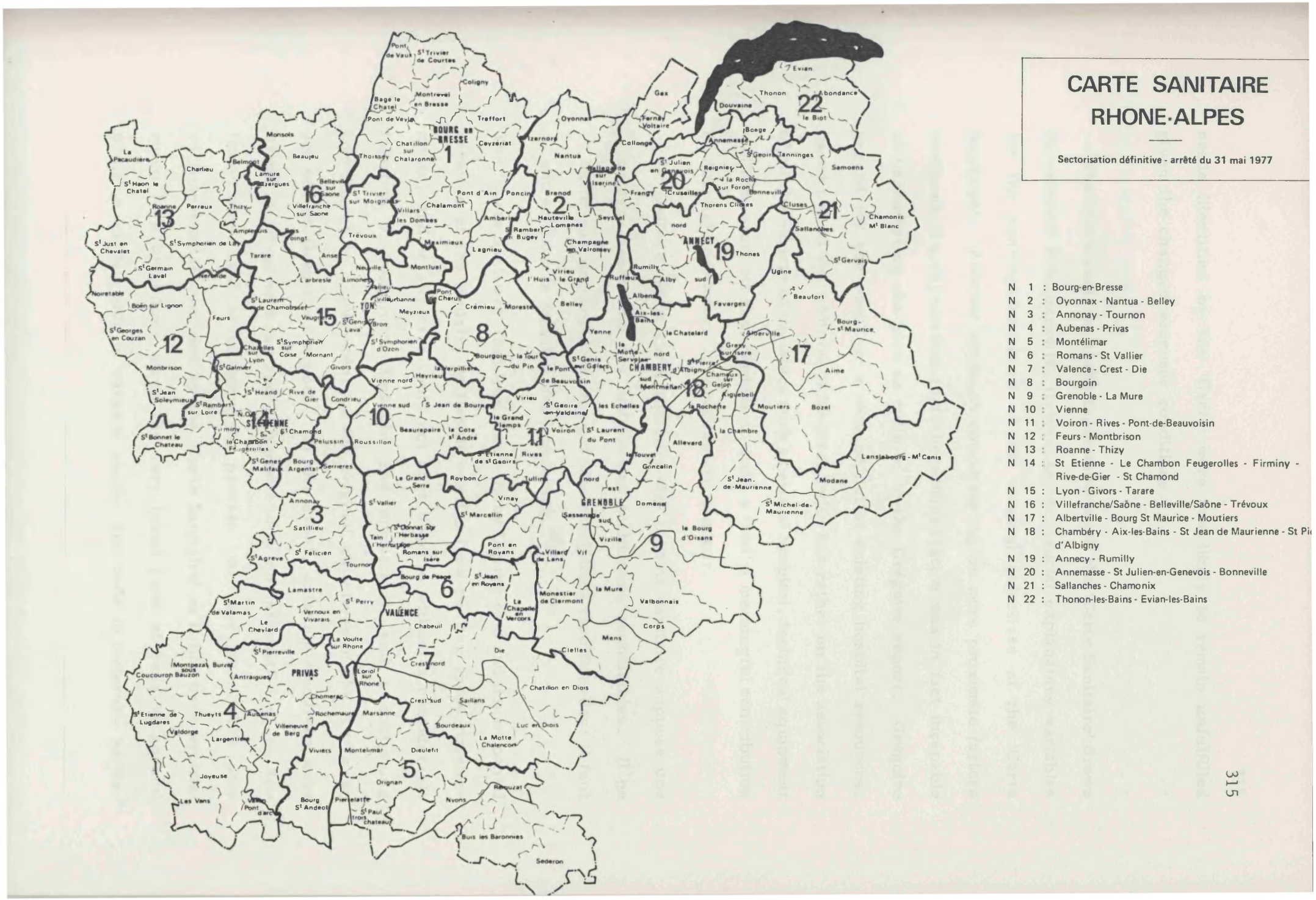
The reality of the 'Carte Sanitaire' is not surprisingly somewhat different. The practical problems of implementing the scheme, the time taken to draw it up, and the deteriorating economic context, all contributed to change its eventual impact on the hospital system. Over the seven years it took to establish the framework of the 'Carte Sanitaire', a number of factors intervened which gradually transformed the aims of the decision makers at the Ministry of Health and hence the ends to which the 'Carte Sanitaire' was put. Probably the most important factor was the changed economic climate.

At the time the 1970 Hospital Law reached the statute boks, the French economy was boming with GNP, growing at a rate of 5% per annum. The crises of 1963, '66 and '68 had been surmounted. There was full or nearly full employment. Between 1960 and 1970 the number of hospital beds increased by 17%. By the time the 'Carte Sanitaire' became operational in 1977, the economic conditions were very different. The growth rate had fallen to about 3%, unemployment was rising, and the

'crise du pétrole' had had an especially severe impact on the French economy. In chapter three the close link between economic conditions and the finances of the health insurance institutions have been explained. As a result of these links the 'crisis' of the finances of the 'Sécurité Sociale' became more and more acute in the second half of the seventies. The hospital sector, which accounted for an increasing proportion of the Insurance Funds budget, became one of the main targets for cuts.

As almost 70% of hospital spending is accounted for by personnel costs, and as the number of personnel is largely a function of bed numbers, it seemed clear at the time that the way to reduce the rate of increase in hospital spending, was to reduce bed numbers. Another argument in supoport of this approach was the belief that in the case of health care, demand was to a great extent determined by supply. The 'Carte Sanitaire' therefore became the instrument for achieving these policy objectives, and not as originally conceived the instrument for planned expansion of the hospital system.

Another possible explanation of the transformation of the 'Carte Sanitaire' from an ambitious tool for planning a comprehensive hospital system based on the health needs of the population, to one of a variety of government measures used to attempt to reduce the health budget is that the 'Carte' arrived too late. According to the President of the CNES, by the time the 'Carte Sanitaire' was operational, the great hospital building boom of the period 1960-1970 had burnt itself out, and that therefore firstly France already had too many hospital beds, and that secondly it was too late to attempt to plan a rational hospital organisation and structure. In other words the hospitals that should not have been built were already in service or under construction, and those unfulfilled



CARTE SANITAIRE RHONE-ALPES

Sectorisation définitive - arrêté du 31 mai 1977

N 1 : Bourg-en-Bresse
N 2 : Oyonnax - Nantua - Belley
N 3 : Annonay - Tournon
N 4 : Aubenas - Privas
N 5 : Montélimar
N 6 : Romans - St Vallier
N 7 : Valence - Crest - Die
N 8 : Bourgoin
N 9 : Grenoble - La Mure
N 10 : Vienne
N 11 : Voiron - Rives - Pont-de-Beauvoisin
N 12 : Feurs - Montbrison
N 13 : Roanne - Thizy
N 14 : St Etienne - Le Chambon Feugerolles - Firminy - Rive-de-Gier - St Chamond
N 15 : Lyon - Givors - Tarare
N 16 : Villefranche/Saône - Belleville/Saône - Trévoux
N 17 : Albertville - Bourg St Maurice - Moutiers
N 18 : Chambéry - Aix-les-Bains - St Jean de Maurienne - St Pierre d'Albigny
N 19 : Annecy - Rumilly
N 20 : Annemasse - St Julien-en-Genevois - Bonneville
N 21 : Sallanches - Chamonix
N 22 : Thonon-les-Bains - Evian-les-Bains

needs identified by the 'Carte' were now likely to remain unfulfilled given the changed economic conditions.

The above analysis of the implementation of the 'Carte Sanitaire' draws on external environmental factors as the crucial explanatory variables for the non-implementation of the original objectives of the 'Carte Sanitaire'. Another approach concentrating on more proximate factors produces the explanation that the administration was in fact incapable of implementing the plan as outlined in the Grégoire report. Grégoire argued for the need for a detailed list of existing hospital resources, based not on the addition of hospital beds, but rather on the association of all the variety of variables such as size of hospital, technical equipment qualified staff etc that combine to make a 'bed' a meaningful contribution to hospital resources. Thus Grégoire argued:

> Le contenu de la carte sanitaire des besoins sanitaire suppose une analyse assez fine des installations techniques souhaitables. Il ne suffit pas de considèrer les grandes disciplines traditionelles: il faut entrer dans le domaine des spécialités.[38]

The 'Carte Sanitaire' that was drawn up by the regional and departmental services of the Ministry of Health was far from meeting these requirements, and in any case could not have done so without a considerable injection of resources, financial and intellectual, and a continuing commitment by Government to the original objectives of the 'Carte' as set out in Grégoire's report. In the event, existing resources were listed in terms of beds and equipment with no information as to how these were used or combined to provide 'real' services. The only additional detail provided by the 'Carte Sanitaire' as it has been implemented is a breakdown along the very broad lines of beds in general medicine wards, beds in surgical wards, and beds in maternity wards.

This simplified version of the 'Carte Sanitaire' however took over seven years to draw up. To produce the type of planning instrument described by Grégoire would therefore have taken far longer. But it is worth asking whether those responsible for the implementation of the 'Carte Sanitaire' ever had the commitment to such an ambitious policy?

In an interview conducted with a civil servant in the office involved in supervising the drawing up and implementation of the 'Carte Sanitaire' was told that the 'Carte' was 'simply a means for controlling and regulating hospital construction, with no pretension to measure real health needs'. Another actor closely involved in the policy process, a member of the cabinet of the Minister of Health, told me that the 'Carte' was one amongst a number of strategies for reducing the cost of the hospital system. The 'Carte Sanitaire' as it came to be implemented therefore had different and simpler aims from those proposed in the Grégoire report, and this partly because the Ministry of Health did not have the resources to draw up the type of plan Grégoire proposed, but also because objectives had changed. Grégoire's proposals may then have been rational, but it could be argued that they were hardly practical. The concept of health needs and how they should be measured can hardly be described as 'precise' formulation of policy in the sense used by Thompson. Health policy analysts and medical sociologists still find this a most fertile area for disagreement.[39] It was hardly reasonable therefore to expect an already hard pressed administration to discard the convenient and simple system of counting beds, for the gelatinous concept of 'health needs'. Thus in one sense the very rationality of the 'Carte Sanitaire' was one of its faults.

The impracticability of Grégoire's proposals in the face of the

resources available to the Ministry of Health is one explanation for the displacement of policy goals. Another reason was the lack of commitment to the policy goals on the part of the policy implementers. However, as we pointed out earlier, those responsible for the implementation of the Grégoire report had little if anything to do with the formulation of the policies, and it is clear above that their commitment was to a policy for rationing hospital care as opposed to the rationalisation of the hospital system as proposed by Grégoire.

If one judges the 'Carte Sanitaire' on the basis of these criteria, in other words to what extent it succeeded in rationing hospital beds, then it has been a relative success. Between 1963 and 1975 the total number of hospital beds in France increased at an average rate of 20% p.a. Since 1975 the number of hospital beds has remained static and even shown signs of beginning to decrease.[40]

However, looking at the proportion of hospital construction projects authorised after the introduction of the 'Carte', there is apparently little change. In 1964, 69% of projects proposed in the private sector were authorised by the relevant authority. In 1968 this figure fell to 31% and remained unchanged until 1972. After 1973, that is after the introduction of the new system for processing proposed hospital projects but before the final elaboration of the 'Carte Sanitaire', the rate of authorisations actually increased to 45% per annum. Statistics are only available for the private sector as the system whereby hospital projects in the public sector were sanctioned were completely different. However, J. de Kervasdoue has argued that during this period the public sector bore the brunt of government economies in this area.[41] This suggests that the stabilisation in bed numbers described above is attributable

mainly to changed economic conditions rather than the effectiveness of the 'Carte Sanitaire' as a means of controlling hospital building.

The ultimate object of the rationing exercise implemented with the 'Carte Sanitaire' was, as I was told by a top aide to the Minister of Health, to reduce the cost of the hospital system. On this criteria the policy has been less successful. Throughout the seventies the cost of the hospital system continued growing at a rate of between 17% and 20% per annum, and by 1979 the proportion of the total health budget consumed by the hospital system passed the 50% mark (see graph in chapter five, page 168). So, while bed numbers have been reduced the immediate aim of the implementation of the 'Carte Sanitaire', the cost of the health system, the ultimate objective of the health policy makers, has continued to increase at a rate far above that of inflation.

8.xii. **Conclusion**

The issues discussed, and the solutions recommended by Grégoire, illustrate the important influence of current 'ideas' on the policy making process. The problems identified by Grégoire were not discovered overnight, but had long been the subject of discussion and debate. The various solutions to the problems discussed by Grégoire in the report were not new either. They had all been raised at one time or another by journalists in the specialist press, spokesmen for one or another interest group, not to mention academics studying the health system of France and elsewhere. Grégoire's merit, and the merit of that part of the French Administration whence he came was to produce a synthesis of current thinking, and to select what he saw as the most rational solutions. However, rationality here is the rationality of the policy maker. The solutions proposed were compromises which the author felt,

given the circumstances, were the most likely to succeed, and not the best solution to a given problem.

The 1970 Hospital Law also illustrates a number of important points about the policy making process in France. The importance of the role played by the 'Grands Corps' in the policy process, and the permeation of a common rationality amongst its members, can be seen in the early stages of the formulation of the Law, but although the method adopted by Grégoire was admirably rational, the actual process by which the policy reached the statute books was not. This involved a certain amount of chance, the determination of an individual to leave his mark on the organisation of the hospital system, and a certain amount of expediency on the part of the Minister. However, once the policy had been formulated, the strength of the 'Grands Corps' network is also shown to be one of its weaknesses. After the initial conception stage, the policy became the responsibility of the civil servants of the Ministry of Health, the majority of whom did not share the same ethos as the members of the 'Grands Corps', but who were given the task of translating the 'rational' proposals of the Law into 'practical' pieces of legislation. The separation of policy conception functions, and policy implementation functions, meant that the context of proposals was lost, and hence in terms of the analysis of policy, that the 'armchair rationalist' approach can only supply a small part of the explanation of policy.

There are thus two clear stages in the policy making process, the policy formulation and the policy implementation process. Different factors are relevant to the different stages in the process, and other factors affect both. Thus it is clear in the case of the formulation of the policy that the 'Grands Corps' played a crucial role, and that current

ideas on administrative reform and issues in the health field greatly influenced the policy makers. Grégoire's proposals concerning the creation of hospital 'syndicats' closely resembled and had the same objectives as the reform of local government in 1964. Not surprisingly they met with the same problems. Grégoire's suggestions for the reform of the system of central government supervision of hospital administration can be clearly situated in the wider debate raging at that time over the merits and disadvantages of 'decentralisation' and 'deconcentration'.

Although it is possible to present the second stage of the process as another example of the 'Bureaucracy' highjacking policy and frustrating the intentions of both the policy makers and Government, it would be wrong to argue that this was a particularly French phenomenon, and that the non-implementation of the 'Carte Sanitaire' was due to the characteristics of the French bureaucracy. Indeed, as I have argued, it is not clear at all that the 'Carte Sanitaire' was not implemented. To say this one must show that the aims of the policy were not achieved, but this is impossible as these aims changed over time in response to changing economic conditions. In the sense then that the 'Carte' proved to be a flexible policy making tool which could be adapted to the different requirements of a constantly evolving situation, then it can be argued that this aspect, in any case of the 1970 Hospital Law , was successfully implemented.

On the other hand, if one is to argue that the 'Carte Sanitaire' is another example of non-implementation, in this case it would be wrong to attribute this to the traditional features of the bureaucratic and centralised French State. Above I have suggested a number of possible policy based explanations for the 'non-implementation' of the 'Carte

Sanitaire' as described in the 1970 Hospital Law. Thompson's criteria of 'resources' and 'commitment', and his conceptualisation of policy as a hypothesis also prove more useful approaches to understanding how the 'Carte Sanitaire' developed. The eventual use to which the 'Carte' was put becomes almost inevitable when one considers the policy hypothesis made by Grégoire, the resources available to the Minister of Health, and the commitment of the policy makers. The initial policy hypothesis was ambitious, the resources were widely recognised to be inadequate, and finally the separation of policy making and policy implementation functions meant that the commitment to carry the policy through was not there. Of these three factors only the last can be attributed to the specific characteristics of the French political system, and even this is by no means unique to France.

Finally, two major factors which affect both the policy formulation stage and policy implementation stage, 'time' and 'external economic conditions' should be considered. The 1970 Hospital Law was a reaction to a given situation, and within a given economic context, by the time the 'Carte Sanitaire', the major proposal off the Hospital Law, was drawn up, both the initial problem and the economic context had changed. Those responsible for the implementation of the 'Carte Sanitaire' used it as a means for tackling the problems facing them at the time, a sign of flexibility with the means available to them, and not for resolving the problems identified in 1970 with the means that might have been available in 1970. In this light the 'rational policy formulation' process identified by the 'armchair observer' is irrelevant to understanding policy, and it is the implementation and the factors influencing the implementation of policy that are the most significant, both in terms of 'how governments work' and in terms of policy impact.

Chapter Nine

THE IMPLEMENTATION OF HOSPITAL POLICY IN THE RHONE-ALPES REGION

9.i. Introduction

In chapter two I argue for a broader definition of the concept of 'policy' as a first step to a more complete understanding of the nature of what governments do. This definition includes not just the rules and regulations churned out by government departments or the statements of intent of government ministers, or even the projects of the planners, but also the actions taken by government in pursuit of declared or undeclared aims, as well as the impact of those actions. In this case an analysis of the implementation of hospital policy is especially relevant given the importance of local government and centre-periphery relations in the literature on French politics and government. In this chapter I will asses the extent to which the existing theories and literature on French local government and politics provides a means for explaining and understanding the way in which the 1970 Hospital Law was implemented in a given region, and the contribution that a policy based approach to the subject can make to this understanding.

Before giving a brief description of French local government and the place of hospitals within that structure, I will describe and justify the choice of the Rhône-Alpes Region for this case study. In the third section the mechanics of the implementation of the 'Convention Nationale' will be described, followed by an examination of the roles and attitudes of the various actors involved. On the basis of the information collected

during a series of interview in the region during July-August 1980* I will assess the degree to which Health policy appears to confirm the existing theories, and where other approaches may provide equally if not more satisfactory explanations.

9.ii. **The Rhône-Alpes Region**

The Rhône-Alpes Region is not a typical region, if such a thing exists. With a total population of over five million it is the second most populated in France and, in terms of surface area, the largest of the regions. It is made up of the Departments of the Ain, Ardèche, Drôme, Isère, Loire, Rhône, Savoie and Haute-Savoie. The regional capital is Lyon, one of the largest French cities after Paris, which has always been an important hospital centre with a national and international reputation. In terms of hospital resources the region as a whole is well provided for. However the size of the region means that within its boundaries it contains many of the contrasts that can be found at the national level. Thus the densely populated and industrialised area of Lyons can be contrasted with the rural and underpopulated Ardèche. The town of St. Etienne, capital of the coal mining Department of the Loire, and the home of a number of traditional industries, including the old and fading giant 'Manufrance', can be contrasted with Grenoble, capital of the Department of Isère and a centre of the expanding new electronics and microchip industry.

The same contrast can be found in the distribution of hospital resources. Lyon with its university hospitals has a high ratio of beds to population, but Bourgouin, a rural area to the east of Lyon is well

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* see Annex 2 for list of local actors interviewed.

below the national average in terms of hospital resources. Clearly, other regions illustrate the extremes of under and over provision more dramatically. The bed-population ratio in the Nord-pas-de-Calais is well below the national average, and the Paris Region is well above the national average, but in my view it would have been wrong to take these as areas for study, unless the object of the exercise was to highlight 'inequality' in the provision of hospital resources, rather than the political process of the provision of those resources. In the first instance one is seeking to explain an atypical situation, in the second, as far as possible, one is seeking to explain the norm, which is surely more relevant.

In his article comparing the municipalities of Montpellier and Nice, Jerome Milch has clearly established the importance of party politics as a factor influencing local policy making.[1] The Rhône-Alpes Region provides the opportunity to test this theory in the health arena. The political forces in the Rhône-Alpes Region, like those in the nation as a whole, are finely balanced. In the second ballot of the 1974 Presidential elections, Giscard d'Estaing received 51.6% of the vote against the 48.2% cast in favour of F. Mitterrand in the region. The tables were turned at both the national and regional levels in 1981, with Mitterrand winning 51.8% of the vote against 48.2% for Giscard. In both 1981 and 1982 Giscard received strong support in the Ain, the Ardèche, and the Haute-Savoie, while Mitterrand has traditionally drawn strong support from the Departments of the Drôme and the Isère. In the remaining Departments the political forces are evenly balanced.[2]

In the 1978-81 parliament the Region was represented by seventeen members of the Union pour la Démocratie Française (UDF), nine members

of the 'Rassemblement pour la République' (RPR), thirteen Socialists, and three Communists. The Drôme and the Isère are strongholds of the left. Here the Communists and Socialists won 8 out of 10 of the seats available. In the 1981 elections for the National Assembly the left benefited from Mitterrand's success in the Presidential elections, winning twenty-seven of the forty-two seats in the region. The Union pour la Nouvelle Majorité (UNM), the electoral coalition formed by the parties of the right to fight this election, only managed to win fifteen seats and to hold their majority in the Departments of the Rhône and Haute-Savoie.[3] This shows that the Rhône-Alpes Region, while not a carbon copy of the national situation, does reflect quite closely the political divisions and strengths at the national level.

The Mayor of Lyon and also a Senator was Francis Collomb, the last in a long line of Mayors of Lyon who have claimed to be independent, but who in recent years have increasingly come to be identified with the parties of the ex-majority. In Grenoble, the mayor at the time was Hubert Dubedout, a senior figure in the Socialist Party, and a member of the National Assembly. In St. Etienne the mayor was Joseph Sanquedolce, also a Senator, but this time a member of the Communist Party. Thus the three main towns in the area are controlled by different political parties which will enable me to re-examine Milch's theories in the context of hospital policy.

Another feature of French local government highlighted in the literature and evident in the region is the phenomenon of the 'Cumul des Mandats', or the right of politicians at the national level to hold local office. Raymond Barre, Prime Minister until 1981, was elected member of the National Assembly for a constituency in Lyon in 1978. Although

he was obliged to relinquish his seat as soon as he was reappointed Prime Minister, he continued to foster his relations with his constituency, and was re-elected in 1981. In the Loire, Michael Durafour and Lucien Neuwirth, both ex-Ministers and Deputies, also had strong local bases as members of the departmental and regional councils. In the new Socialist Government, J.P. Cot in the Haute-Savoie, Charles Hernu in the Rhône, Jean Auroux and Georges Fillioud in the Drôme, were also Deputies and held local offices in the respective Departments. On the basis of the existing literature, one might expect these actors to influence hospital policy at the local level.

The selection of the Rhône-Alpes Region is thus justified by the fact that its size guarantees the possibility of finding many of the extremes of over and under provision in hospital resources, as well as the political variations that exist in the nation as a whole, without those extremes or variations themselves becoming the focus of the analysis.

9.iii. **The Administrative Framework**

France has traditionally been given as the model of the centralised State. The hierarchical and pyramidal structure of central and local government inherited from Napoleon goes some way to explaining this, but this image has also been perpetuated by many analysts over the years concentrating on the legal and administrative aspects of local government at the expense of politics. The degree of centralisation in France is now being questioned, and this policy based approach to the question is designed to contribute to this debate.

The French administrative system is made up of three levels of local

government. The basic unit of French local government is the commune. Electors in the 36,383 (in 1978) communes elect a municipal council, which in turns elects a mayor. The mayor, who is elected for six years, is both the executive officer of the commune and the representative of the State in the commune. Above the commune are the ninety-six 'Départements', each with a directly elected council, the 'Conseil Générale', and finally, the most recently created level of local government, the twenty-two Regions (created in 1972). The Region is not an administrative unit in the same sense as the commune and the 'Département'. Its legal status is that of an 'établissement public', in other words the same as a hospital. Its functions are limited to planning and to promoting economic development. Up until recent reforms the regional council was made up of appointed officials and indirectly elected representatives. In each 'Département' the State is represented by the Prefect who is responsible for supervising the activities of the communes with the aid of his sub-prefects, and coordinating the external services of the State. The formal powers of the Prefect are extensive. He is the direct representative of central government in the department. His immediate superior is the Minister of the Interior, but he also controls the external services in the department of all the other ministries. The Prefect draws his power from the 'tutelle' he exercises over the activities of the communes. This confers on him a number of formal powers such as the right to dissolve council meetings, and to veto the budget voted by the commune, as well as possibly more significant powers to influence policy decisions of local councils. The most significant characteristic of the office however is its reputation. Like the Prefect in Stendahl's 'Lucien Leuwen', the Prefect is still seen as being the eyes and ears of the government in the department and as being a master of political intrigue, even if in reality his powers are limited.

It is now commonly held that the power of the Prefect has been exaggerated.[4] In chapter one I have set out the various exceptions to the rule that limit the theoretical powers of the Prefect, the complicated links between the Prefect, the field services, and local 'notables' and their interdependance. The complexity of the system and the contradictions that abound are such that, according to Machin, it is impossible to fit the system into any of the pre-established models of State and society.[5] The analysis of the implementation of the 'Carte Sanitaire' that follows in general confirms the complexity of this system, but also shows a number of characteristics that are peculiar to the field of health policy.

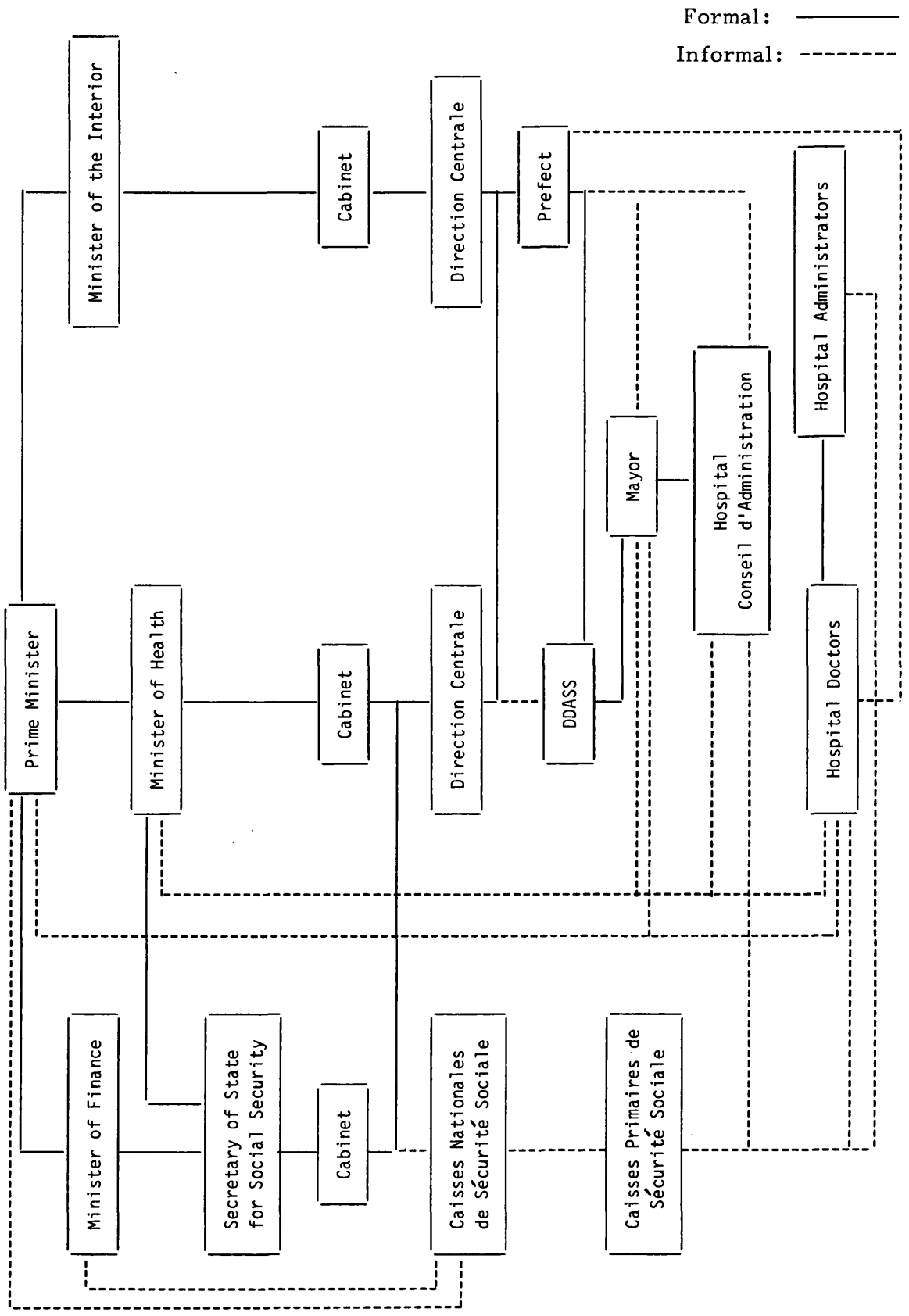
9.iv. **The Hospital in the Framework of Local Government and Administration**

One significant difference that is immediately apparent in this area of policy is the place of the hospital in this framework. As I have argued earlier the French hospital system has only recently come under central government conrol, and, as such, the framework of the system does not fit the traditional model of French administration (see figure on page following). There is no equivalent in France of a 'National Health Service' with one, two, or three tiers of administration. For the reasons outlined in chapter 4, each hospital is an independent unit attached to a commune, with its own administrative and medical staff, and legally classified as an 'établissement communal'. It is only since the 1970 Hospital Law that the concept of a 'Service Public Hospitalier' has existed. But this is a concept that still remains to be transformed into a reality.

As described earlier the responsibility for running public hospitals

Influence and Lines of Communication in the Health Policy Field

(Adapted from: Revue Française des Affaires Sociales, No. Speciale, 60eme anniversaire du Ministère de la Santé, Vol.34, No.4, oct-déc 1980) p544.



is shared between the mayor of the town in which the hospital is located, who automatically becomes president of the 'administrative council' of the hospital and the 'Directeur' of the hospital. One of the aims of the 1970 Hospital Law was to increase the powers and reponsibilities of the director, who nevertheless remains in the invidious position of being an employee of the municipality, yet dependent for his career advancement, and receiving most of his instructions, from the Ministry of Health.

The Prefect and the external services of the State have certain powers of 'tutelle' over the administration of hospitals as they do over the administration of the commune. For example the decisions of the 'Conseil d'Administration' are not valid until they have been approved by the Prefect. However the most significant function of the Prefect is his power to set the 'prix de journée' ('patient day rate'), which determines to a certain extent the income of a hospital and hence its budget. The Prefect also has the power to reject the budget proposed by the administrative council and to replace it with one prepared by his own administrative services. In extremis he may dissolve the administrative council of the hospital and administer it directly.

A broad overview of the hospital system and local government suggests two very different organisations moving in opposite directions to become more similar. The tendency in local government over the last twenty years at least has been to relax central controls, and to allow a greater degree of local freedom in administrative decision-making within certain guidelines. In the case of hospitals, developments have been in the reverse direction. Up until 1945 central government control over the hospital system was tenuous. Hospitals, whether public or private,

functioned virtually as autonomous local units. Since 1945, and the introduction of collective finance of hospital care, with the escalation of the cost of hospital treatment, the movement has been towards increasing central control of the hospital system. Up until 1970 however, this control of the hospital system was indirect, exerted through the existing local government structures and the power of 'tutelle' of the Prefect. The 1970 Hospital Law took one further step by intrducing a nationally based system for controlling and planning the growth of the hospital system, at the same time as taking the first tentative steps towards detaching the institution of the hospital from the commune.

Therefore the processes involved in the implementation of the Hospital Law, and again I should stress that it is from a broad perspective, were somewhat different from those involved in the reform of central local government relations. In the case of hospitals, we have a government attempting to impose order on a dislocated, imperfectly controlled and almost anarchic system in response to the changing nature of hospital care and the increased financial demands implied by that change, whereas in the case of local government the movement was towards relaxing the highly centralised control mechanisms of the State.

9.v. **The Implementation of the 1970 Hospital Law**

I have already set out, in chapter eight, the background to the 1970 Hospital Law and analysed its multiple objectives and how these evolved over time. In this chapter the focus of attention is on the way in which policy makers set out to achieve these aims, and the impact of their actions on the hospital system. The aims of the Law were ambitious and covered many aspects of the hospital system, but here I shall concentrate on the 'Carte Sanitaire', firstly because, as I argue in

chapter six, this eventually became the key aspect of the Law that government actors sought to implement. The second reason is that the 'Carte' involved actors at all levels of government and within hospitals themselves, whereas other aspects of the Hospital Law were restricted to either internal reforms of the hospital administration, or to reforms of the links between hospitals and municipalities.

The first step towards the implementation of the 'Carte Sanitaire' involved drawing up the boundaries of the regions and the sectors of the new map and collecting the data on the existing and authorised hospital resources within these areas. As the introduction of the concept of the 'Carte Sanitaire' followed shortly after a period of reorganisation of local government in which the main aim had been to harmonise administrative areas and which created a new administrative entity, the Region, the logical choice was for the boundaries of the health region to coincide with the new administrative region. The drawing of the boundaries of the 'sectors' within each region was a more complicated matter as these had to comply with certain criteria of population, lines of communication and existing hospitals drawn up by the Ministry of Health. The existing Departments were too large for this purpose, and the 'cantons' and 'arrondisements' either too small, or inappropriate for other technical reasons. The 'secteur' of the 'Carte Sanitaire' were therefore hybrid areas, and the preferences of local actors, not always satisfied.

In the Rhône-Alpes Region the boundaries of the sectors within the region were eventually finalised on the 7th December 1973 by an 'arrêté' of the Minister of Health. The region was divided into twenty-two sectors, ranging from that of Lyon, the largest, with a population of

1.3 million, to Annonay-Tournon, with a population of 78,000 inhabitants, the smallest.*

The next stage of the process involved drawing up an inventory of existing and authorised hospital resources by sector and by region. The responsibility for this was delegated to the 'Directions Départementales des Affaires Sanitaires et Sociales' (DDASS) and proved to be a long and complicated task. In the first place a certain amount of confusion was caused by the fact that a number of sectors overlapped the boundaries of 'Départements', which meant that different departmental services had to cooperate to collate their results. Secondly the process also involved counting non-existent beds. In the public sector, in particular, where the normal time span from authorisation of a project to completion was over ten years, a number of hospital beds existed only on paper. For some a construction site provided evidence that some day these would contribute to the existing hospital resources of the region. For others they remained figments of the imagination of a local mayor or doctor.

In the private sector, the problem was somewhat different. Private clinics are in general much smaller but are also far more numerous. Here the DDASS had to rely to a great extent on information provided to them by the managers of these institutions, as the only alternative would have been to visit every clinic and literally count each individual bed.

As well as totalling the number of beds, the 'Carte Sanitaire' required

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* see Annex 1 for the complete 'Carte Sanitaire' of the Region, and map on p315.

that these be classified according to their use. Gregoire's initial report proposed a comprehensive and detailed classification, encompassing many criteria. The system eventually adopted for the 'Carte Sanitaire' was far more basic, dividing hospital resources into beds used for general medicine (M), surgical beds (C), and maternity beds (O). One of the objects of this exercise was to distinguish between long, medium and short term hospital beds. In practice the field services found it almost impossible to draw such distinctions. In many rural hospitals all beds were used for long term care, and classifying them as such would have meant the institution losing the status of hospital. This in turn would mean that it would lose a proportion of the funds provided by the health insurance organisations, and become dependent on the 'aide sociale', a service run by the DDASS. In other larger hospitals beds were used for different purposes according to need. In the end the attempt to assess staffing levels or the standard of equipment and the trained technicians needed to make a hospital bed functional was abandoned. Thus at the end of this exercise a member of the DDASS in Lyon concluded that 'la concepte du lit veut strictement rien dire', an indication that the 'implementators' had little confidence in the policy tool in question.

The final stage in the process of implementing the 'Carte Sanitaire' involved setting the criteria of need according to which future decisions on hospital construction would be determined. This was done by calculating the average rate of bed occupancy in the three chosen categories and deducing from this a standard bed:population ratio (see table following). These ratios were weighted according to the particular characteristics of each region. On the basis of this the Minister set maximum and minimum ratios for each region which were submitted to the newly created 'Conseil Regional d'Equipment Sanitaire' (CRES) and

the 'Groupement Interhospitalières'. These bodies in turn calculated according to their appreciation of local needs a ratio for the region and each sector, which they in turn submitted to the 'Conseil National d'Equipment Sanitaire (CNES). Finally the CNES, on the basis of the information provided by the regions and the maximum and minimum indices set by the Ministry, proposed a national plan to the Ministry of Health.

Maximum and Minimum Bed/Population Indices

Sector of <150,000 inhabitants		With School of Medicine	Sector of >150,000 inhabitants
Medical	2.3 to 2.5	+ 0.20	2.5 to 2.7
Surgical	1.8 to 2.0	+ 0.20	2.1 to 2.3
Obstetrics	0.4 to 0.5	+ 0.05	0.4 to 0.6

(Source: Arrêté Ministériel du 30 octobre 1973)

In the case of the Rhône-Alpes Region, according to a local official who took part in the exercise, the indices put forward by the 'Groupement Hospitalier' to the CRES were without exception above the maximum levels recommended by the Government. The CRES reduced these by various amounts before forwarding their proposals to the CNES. The CNES in their turn reduced the proposed ratios even further. According to A. Bernard, the President of the CNES, this was the pattern followed in every region.

The finalised 'Carte Sanitaire' was eventually published in 1977 by the Minister of Health. As explained in the previous chapter, the aims of the 'Carte Sanitaire' had by this time changed from planning to rationalising health care, and the indices finally authorised by the Ministry of Health had once again been scaled down. The end result

of this was that in the Rhône-Alpes Region the 'Carte Sanitaire' indicated an overall excess capacity of 10,377 beds, mainly in general medicine. However, while the 'Carte' indicated an overall excess capacity, it did pin-point a number of areas in which there was underprovision*. Nevertheless, the effect of the 'Carte' was virtually to freeze hospital resources at their existing level and to rule out any growth in services in the region.

Hospital Resources and Estimated Needs in the Rhône-Alpes Region
Population 1978: 4,941,339

INSTITUTION	MEDICAL	SURGICAL	OBSTETRICS
Public Hospitals	11,478	7,297	2,004
Private Clinics	1,918	5,564	1,194
sub-total	**13,396**	**12,861**	**3,198**
Rural Hospitals	1,483		47
Sanitoria	1,183	121	
Thermal Resorts	767		
Military Hospitals	90	90	
sub-total	**3,523**	**211**	**47**
TOTAL	**16,919**	**13,072**	**3,245**
NEEDS as determined by the 'Carte Sanitaire'	10,103	10,443	2,313
BALANCE	+6,816	+2,629	+932

(Source: 'Préfecture de la Region Rhône-Alpes)

It has been argued that in France those who have the power to decide lack the relevant information, and that those with the relevant information

* see Annex 1.

lack the power to decide.[6] This seems to fit the case of the 'Carte Sanitaire' where the DDASS was unable to refine the criteria for assessing existing resources despite their awareness of the deficiencies of the 'Carte' gained from practical experience of the problems. Thus it appears that the way this part of the Hospital Law was implemented confirms the model of France as a centralised State. A set of norms were laid down by central government and despite the fact that regional and local commissions were consulted, the final form of the 'Carte' was imposed by central government with very little attention paid to the recommendations of local actors. It also supports the theory that poor communication between decision makers and implementors is another characteristic of the French State.

However, the question arises whether this is a characteristic of the French system of government or a phenomenon common to hospital policy making in general. The method for evaluating the nature and performance of hospitals is a common problem in a number of countries. Although the criteria of 'beds' is in general use, it is widely recognised that this is an unsatisfactory concept.[7] However, the problem of replacing it with an equally simple but more accurate system of measurement has not been solved. The function of hospitals is in theory to produce health or to cure, but unlike a factory, one cannot measure the efficiency of hospitals in terms of 'x' number of healthy people produced per week. Nevertheless, all administrations, not just the French, seek quantifiable criteria on which to base their actions.[8] While the problems faced in the implementation of the 'Carte Sanitaire' may therefore be seen as characteristic of the French administrative system, they may equally be portrayed as part of a wider phenomenon common to hospital policy making in general.

As a result the approach adopted by Thompson and Majone might prove more fruitful as a basis for examining the implementation of the 'Carte Sanitaire'. This approach leads us to ask in the first place what was the 'policy hypothesis', or what actions were seen to be required to produce what results. While this was quite clearly defined initially, by the time the 'Carte' came to be implemented objectives were in the process of changing and it was not clear whether the aim of policy was to provide a planned extension of the hospital system or to ration the supply of hospital resources. Secondly this approach leads us to look at the means made available for achieving the desired end. In the case of the 'Carte' , the DDASS was expected to perform a complicated and time consuming task without any additional resources. This in turn brought the time factor, the third element in Thompson's approach, into play. The implementation process took so long that the assumptions on which it was based were inappropriate by the time it came to be implemented.

Before any conclusions can be drawn however it is necessary to look more closely at the role played by the different actors in the process. Crozier and others might argue that France is highly centralised, but they also point out the considerable countervailing powers and a sort of system of 'checks and balances' exerted by local government actors at different levels. Can these same forces be identified in the field of hospital policy administration, and how has this affected the implementation of hospital policy in the Rhône-Alpes Region?

9.vi. **The Prefect and the Local Administrative Services**

In theory the key figure in local government is the Prefect. In the field of hospital policy the Prefect is also on the face of it a key actor.

The 1964 reform of local government and administration in France placed the Prefect at the head of all local government services, including the services of the Ministry of Health, and devolved certain responsibilities to the Prefect. The 1970 Hospital Law re-emphasised the importance if the Prefect in this field by devolving more decision making responsibilities to this level and by giving the Prefect a clear role in the formulation of the 'Carte Sanitaire'.

Given that by the time the 'Carte Sanitaire' came to be implemented the emphasis of policy had changed from the rational planning of the future growth of the hospital system to rationing health spending, it would not seem unreasonable to expect to see the Prefect playing an important role in ensuring the implementation of government policy in this area.

My research in the three Departments of the Rhône-Alpes Region produced little evidence in support of this hypothesis. For example in the DDASS in Grenoble I was told that the Prefect had delegated the bulk of his responsibilities in this area to the service. The extent of this delegation was illustrated by the fact that only those matters not within the signing powers of the DDASS were listed, and not vice versa.

In all three areas officials from the DDASS confirmed that at no time during the preparation of the 'Carte Sanitaire' did the Prefect attempt to influence their work, and that their final recommendations were passed unchanged through the Prefect's office to the CRES.

One possible explanation is that the Prefect's role in all policy areas

has been exaggerated. The 1964 reform of local government which reasserted the authority of the Prefect in the 'Département' also allowed the Prefect to delegate many of his new powers to the field services. It can also be argued that some Ministries remained more centralised than others. In her detailed analysis of the 1964 reform, C. Gremion argued that the technical ministries, of which the Ministry of Health was one, successfully negotiated to maintain many of the powers of the centre on the grounds that the issues covered by their Ministries were too technical to be devolved to lower levels of government.[9]

Another reason why the Ministry of Health may have felt the need to resist any devolution of its powers is linked to the history of the Health administration. Unlike the Ministry of Education and most others, the Health administration was a recent creation which, as we have argued, had imperfect control over its empire. Rather than reduce its control over local matters, the Health administration was still working to assert its influence fully, and to reduce that of local actors.

The change of policy from planning to rationing hospital care further reinforced this tendency towards centralisation. I was told by a member of the cabinet of the Minister of Health that they were convinced that the only way to ensure a reduction in hospital spending was through tight central control. The reason for this, I was told, was that the Prefects lacked the necessary authority to implement the policies of cost control that the government believed essential, and that therefore these decisions had to be taken by the centre. This was corroborated at the local level, where a member of the cabinet of the 'Préfet de Region' complained that 'Le Ministère de la Santé à très mal joué le jeu de la décentralisation'. In all of the three DDASS's I visited, there were

repeated complaints about centralisation, and what was called 'administration téléguidée' or 'administration par circulaire'.

An example of the increased centralisation of the Ministry of Health is the case of hospital budgets. Up until 1977 the responsibility for authorising hospital budgets lay with the Prefect. In 1977 the Minister of Health on the instructions of the Prime Minister decided to limit the annual increase in hospital budgets to the level of the rate of inflation.[10] The Prefect was instructed to forward all budgets with increases over this limit to the Ministry. What this meant in effect was that the role of the DDASS, which would normally have inspected these budgets, was decreased, and that the Ministry of Health was landed with the task of inspecting 200 to 300 hospital budgets, budgets which had taken local hospital administrators two to three months to prepare. This meant that their decisions were bound to be seen by local actors as arbitrary, and to create a feeling of resentment amongst hospital administrators and in the external services of the Ministry.

Thus it seems that the Ministry of Health, despite the various decentralisation measures of the sixties and seventies, has in fact become increasingly centralised. This is possibly the result of a reaction against the unusual degree of decentralisation that has traditionally existed in this area of policy (compared with other policy areas). Alternatively it might be explained as a product of the economic conditions prevailing in the late seventies, and thus part of a general tendency of the State to reassert its control over local government simply as a means of controlling spending. In other words the decentralisation reforms of the sixties were a function of economic prosperity, and reflected the fact that central government felt able to permit local actors to decide

on the allocation of an increasing proportion of resources. Once economic conditions deteriorated this greater flexibility disappeared.

It thus appears that the Prefect was on the whole bypassed by the Ministry of Health. This was partly due to the fact that central administrators felt that the Prefect lacked the authority to impose the necessarily difficult decisions required if savings on hospital spending were to be achieved, but also to a large extent due to the fact that the Ministry of Health had only recently extended its sphere of influence to cover hospital administration and was therefore all the more zealous in exercising its responsibilities.

The field services are often described in the existing literature on French local government as being closer to local political actors than to central government and as defenders of local interests against the insensitive and distant centre.[11] In the Rhône-Alpes Region the evidence in support of this theory is not strong. The attitudes expressed by the three DDASS in the Region that I visited differ somewhat. In St. Etienne and Lyon there was no question of the DDASS and the Prefect's office being at cross purposes. In Grenoble it was clear that the DDASS had a strong sense of identity and common organisational values. One explanation for this may have been the physical separation of the DDASS from the rest of the Departmental administration in Grenoble. The DDASS in Grenoble had their offices in a modern block separate from the Prefecture. In contrast in St. Etienne the DDASS offices were in the converted attic of the Prefecture. However, in other matters the DDASS in the three towns were very similar. The field services are part of the civil service as a whole, and as such they tend to share the values of the organisation. This was clearly illustrated

by their attitude towards the private sector. The field services, like the rest of the administration, are dedicated to the principle of the 'intérêt générale'. The public hospitals were therefore a natural ally, and the private sector, partly because it was private, but mainly because it was profit orientated and served an 'intérêt particulier', was regarded with disfavour. Officials in the DDASS in St. Etienne were quite open about their hostility towards the private sector. For example they described to me how they attempted to prevent the opening of a new clinic in the town by stipulating that certain technical and safety regulations be strictly applied. However, their attempt failed as the four doctors promoting the clinic had no difficulty in raising the £200,000 needed to meet the additional cost of these modifications.

Apart from the above I found no evidence in the Rhône-Alpes Region of the field services defending local interests against those of central government, or even slightly modifying central government policy. This illustrates the common unifying values that can be found in the local services of the Ministry of Health - identification with the public sector, and service of the 'intérêt général'. This belief in the 'intérêt général' explains another more surprising feature common to the Departmental services in the three towns. In each I heard criticisms from the DDASS of the role played by the social security organisations in the administration of hospital policy. I was told by a civil servant working in the DDASS that the social security organisations were dominated by the local members of the CNPF, and that as a result the organisation tended to favour the private sector. The same official explained that this was not simply a question of principle, but also because they saw things simply in terms of the cost for the insurance organisations, and thus indirectly for the employers.

Another possible explanation for the hostility felt by local administrators towards the Health Insurance Funds is that the 1970 Hospital Law, by giving the social security organisation an increased role in supervising hospital policy and administration, created a rivalry between, on the one hand, the administrative services of the State, and on the other hand a quasi governmental administrative organisation. The aims and objectives of the two organisations were different, and to a certain extent conflicting. The DDASS has broad responsibility for supervising the provision of a number of social services, including hospitals. Their primary function is therefore as providers of benefits. As such their commitment to the 'intérêt général' is easily understood. The social security organisations are essentially financial organisations - their main function is to collect contributions, and to finance health care, but an important secondary function is to ensure that the finances provided are well spent. The two organisations therefore have very different approaches to the same subject.

This conflict of values adds an interesting dimension to Lowi's categorisation of policy types as discussed in chapter two. Lowi argued that the process of policy making and policy implementation differ according to the nature of the policy.[12] In this case we have a classic example of a 'distributory' agency as represented by the DDASS, and a 'regulatory' agency as represented by the Health Insurance Funds. The problem with Lowi's theory is that he suggests that regulatory and distributory policies can be analysed separately. This example above shows that they are often inseparable, and that any analysis of say the 'regulatory' policy function of the Health Insurance Funds would be incomplete without an analysis of the mediatory influence of the 'distributive' policy function as represented by the DDASS, and vice

versa.

Although my research in the Rhône-Alpes Region unearthed no evidence of centre-periphery conflict, there is evidence from other Regions that the local field services did use their key role in drawing up the 'Carte Sanitaire' to achieve ends which were not those of the central policy makers. This came to light in a case brought on appeal to the 'Conseil d'Etat' by a private promoter who had had his application to open a clinic refused on the grounds that the 'Carte Sanitaire' showed the needs of the area to be well provided for. The 'Conseil d'Etat' overturned the decision of the administrative tribunal after finding that a large number of the 'beds' included in the 'Carte' for the Region did not exist. As a result the 'Conseil d'Etat' cancelled the 'Carte Sanitaire' for the whole Bordeaux Region.[13] What had happened was that the local field services, in an attempt to prevent further private sector expansion in the area had inflated the figures on existing hospital resources in the area. Thus when the 'carte' came to be published it showed that the needs of the area were fully satisfied. This obliged the Prefect to reject all applications for permission to open private clinics.

9.vii. **The Mayor**

Along with the Prefect, the Mayor is another crucial figure in French local government and politics. In chapter one I outlined the theories of Crozier, Milch, and others on the role of the mayor and the ways in which he is able to circumvent the hierarchical powers of the Prefect and influence the centre directly. There are a number of reasons why one might expect that the field of hospital policy be no different. The existence of a hospital in a Commune, its size and excellence are all factors which add to the prestige of a town and hence its mayor, in

the same way as the 'piscine chauffée' or the 'stade municipal'. Secondly, a hospital is a major employer and consumer of goods and services, and hence makes an important contribution to the economy of a town. In St. Etienne, for example, the CHR is the largest single employer in the town. A hospital may also be an important vote winner, and in any event the closure of a hospital by central government would be seen as a personal failure on the part of the mayor.

My research in the Rhône-Alpes Region provided little evidence of this type of influence. The representatives of the mayors in both St. Etienne and Grenoble argued that their powers had been reduced by the 1970 Hospital Law, and those of the Prefect and central government increased. In St. Etienne the 'adjoint au Maire' responsible for hospital policy explained that, while in theory the mayor as president of the 'Conseil d'Administration' had some limited powers, in reality his influence was minimal. In Grenoble the 'adjoint au Maire' argued along similar lines. In her view the influence of the mayor was negligible. She explained that the reason for this was that firstly the supporters of the mayor were a minority on the administrative council of the hospital, and that secondly on the rare occasions that the hospital council did unite, as for example on the hospital budget, the Minister of Health has the right to override them.

One of the stated aims of the 1970 Hospital Law was in fact to reduce the influence of the hospital councils. This was achieved by increasing and diversifying the membership of these councils. The wider range of interests now makes it much more difficult for any natural majority against the Prefect to be formed. In the new hospital administrative councils the number of representatives of the health insurance

organisations now matches the number of local politicians. The remaining third of the board is made up of three representatives of the medical and other staff of the hospital and a number of 'suitably qualified' persons selected by the Prefect. In this situation any expansionist coalition of local politicians and hospital doctors can always be defeated by a coalition of the representatives of the Insurance Funds and the Prefect's nominees. A successful coalition against the Prefect between local politicians and the representatives of the Health Insurance Funds is mathematically possible but highly unlikely.

The nominees of the Prefect to Hospital Boards are theoretically selected on the basis of their competence and special knowledge of hospital affairs. However, according to the 'adjoint au Maire' in St. Etienne, the Prefect's nominees to the Hospital Board of the CHR of St. Etienne knew nothing about hospital administration, but were 'pillars of the right wing establishment of St. Etienne'.

In Lyon the situation was slightly different. Here, according to his assistants, the mayor deals personally with questions relating to the 'Hospices Civils de Lyon' (HCL), rather than delegating to an 'adjoint'. However, my request for an interview created a certain amount of confusion in the office of the Mayor as it was felt that there was nothing to discuss. I was referred to the DDASS and to the director of the HCL, as being more competent to answer my questions.

In view of the potential impact of the 'Carte Sanitaire' on the allocation of resources for hospitals in the Regions and Departments it would not be unreasonable to expect to find the kind of 'criss-cross pattern' of influence and the power plays described in much of the literature

on French local government and politics. My research however unearthed no evidence of this type of political influence affecting the way the 'Carte' was drawn up and implemented. In fact the procedures involved in drawing up the 'Carte' gave little scope for influencing decisions to local political actors. Mayors and other locally elected actors were members of one or other of the various commissions that were consulted on the 'Carte Sanitaire' but, as we have seen, the final proposals owed little to the input from these sources. The theoretical needs set out in the 'Carte' were so designed as to prevent any future expansion in the hospital system, and thus were difficult to accommodate with any form of political clientelism. This is not to say that the process was totally apolitical. An illustration of the way political factors did influence the way in which the 'Carte' was used can be seen in the case of the hospitals of Evry and Corbeille, two suburbs on the outskirts of Paris.

Every is a new town that was created partly to balance the effect of Corbeille, an old working class suburb of Paris, part of the Communist controlled area known as the 'red belt' which surrounds the capital, and partly to serve as a dormitory town for the expanding Paris region. The first Mayor of Evry was a member of the majority party and a Deputy in the National Assembly. During his term in office he managed to get the 'Préfecture' of the 'Département' transferred from Corbeille, and to get through a project for the construction of a new thousand-bed hospital in Evry. At the same time a project for the reconstruction of the old hospital in Corbeille, also involving a thousand beds was agreed. During the long administrative process of planning these hospitals, both these projects were reduced to four-hundred bed hospitals. In the meantime the municipality of Evry changed hands. In the municipal elections of 1977 which were convincingly won by the

Socialist party, the 'Conseil Municipal' of Evry was taken over by an alliance of the Communist and Socialist parties with the Socialists as the dominant partner.

By 1979 the municipality of Evry had provided the finance necessary for the purchase of the land, and its share of the cost of building the hospital. The hospital buildings were all but complete, and all that was required was the installation of the necessary equipment and the employment by the Minister of Health of the medical personnel to staff the hospital. However, the hospital remained unused as in the same year the government issued a circular declaring that where an increase in needs resulted from the transfer of population from one area to another, new hospital beds could only be opened if an equivalent reduction was made elsewhere. The medical staff were not made available to Evry as the powerful 'Assistance Publique de Paris', and the Mayor of Paris, Jacques Chirac, refused to reduce the capacity of the Paris hospitals for the benefit of a small suburban hospital and a Socialist municipality. Nevertheless this type of political influence is rare, and the events might just as well be explained in terms of the staying power of the large and well established institution.

Another example of this kind of intervention was found by a research team based at the University of Lille which studied three hospital projects in the Dunkirk area. Again their evidence is indirect, but they argued that the only explanation for a number of decisions which ensured the completion of one of the projects they studied was a visit by the Maire to the Minister of Health. No records of the discussions of that meeting were kept and subsequent correspondence between the Maire and the Minister was not made available to them.[14]

If the Crozier theory on the criss-crossing lines of influence in French local government and politics is accurate then one might expect to find evidence of this in Lyon. The ex-Prime Minister, Raymond Barre, was elected Member of the National Assembly for one of the urban constituencies of Lyon in 1978 and 1981. Although in accordance with the constitution he resigned his seat immediately after being elected to take up the Premiership, in common with other politicians with government portfolios, he continued to maintain close contact with his constituency and supporters. This is common practice in France and ensures that, should a Minister be replaced, or a Governmment defeated, his constituency seat is always there to fall back on. As Prime Minister, R. Barre held arguably the second most powerful position in the land, and was hence ideally placed to influence local decisions. However, according to the director of the HCL this situation was in fact a disadvantage rather than an advantage, as the Prime Minister, for fear of provoking charges of clientelism was scrupulously careful not to intervene in any way in matters concerning his constituency.

If it is the case that in the field of hospital policy the influence of local politicians is minimal, and that the 'jeux d'influence' discovered by the authors discussed in chapter one does not exist, the important question to answer is why this should be so. A possible answer is methodological, in that given the unofficial and secret nature of these forces, local actors are unlikely to divulge the real nature of the local power structure to interested academics. However, my research suggests another more fundamental explanation.

In all three areas investigated there was evidence to support the theory that it is the nature of the policy involved which explains the

lack of involvement of political actors. Firstly I found the political actors uneasy about attempting to influence decisions in this field. According to the 'Adjoint au Maire' of Grenoble, the mayor in many cases abstained from voting on the administrative councils of the hospital where what he felt were technical issues on which he was unqualified to judge were involved. This was confirmed by the DDASS in Grenoble who claimed that hospital policy making was depoliticised because 'it was too serious a matter to be decided on the basis of political considerations'. Secondly I found that, with the exception of Lyon, mayors tend to delegate this area of policy to an 'adjoint', suggesting that health policy is not one of their priorities. Finally, for most decisions involving a large capital outlay, such as the purchase of expensive hospital equipment, or the extension of hospital capacity, the decision is taken by the Minister of Health, and any negotiations or bargaining that takes place tends to be between the 'chef de service' and the Minister of Health. For both hospital policy and primary health care policy the medical profession appears to play a crucial role, for, to a certain extent even at the national level, the same depoliticisation resulting from the technical or special nature of this specific policy area can be seen.

This highlights the role of two new sets of actors whose equivalent is not found in other areas of local politics, and who play a crucial role in influencing the implementation of policy - hospital administrators and the medical profession.

9.viii. **The Hospital Administrator**

The ambiguous position of the hospital director in relation to the Mayor, his employer, and to the Minister of Health who controls his career, has already been pointed out. Different actors in the system

have a different appreciation of the degree of influence of the hospital director. In the opinion of the 'Adjoint au Maire' in Grenoble the hospital director is at the beck and call of the Minister. In contrast, a local government official in Lyon in the office of the Regional Prefect argued that the hospital directors have a strong 'esprit de corps' and that their professional association, the FHF, plays an important part in influencing decisions at the national level. A third view from the DDASS in St. Etienne was that hospital directors are 'tres peu service publique', meaning that they do not share the same values or approach of the local field services, and are seen to enjoy considerable independence.

There are some minor differences in the role played by the hospital directors in the three towns. The director of the 'Hospices Civils de Lyon' (HCL), the largest in the Region, is M. Rochaix, a highly qualified and experienced man who, like the mayor of a large town, draws a certain amount of additional influence from the size of the institution he runs. Like the director of the 'Assistance Publique' in Paris and Marseilles, he is able to negotiate directly with the central administration. Lyon is a unique case in that until recently it enjoyed a special status which enabled it to avoid many of the central controls. This has recently been changed and, according to an administrator of the HCL, central supervision of their actions has since been particularly zealous.

The 'esprit de corps' of hospital directors was quite evident in Lyon. The director, M. Rochaix had formed a team of young assistants, all graduates of the ENSP, to run the HCL. They all shared the same philosophy and a strong sense of loyalty to the director. Rochaix saw the role of the hospital director as being more than just solving the day-to-day problems of hospital management, but also to seek out and

resolve future areas of difficulty before they became chronic. Rochaix was a strong proponent of hospital planning, but his idea of planning had more in common with the old heroic planning of the 'Commissariat Général du Plan' than simple provisional planning. Thus he argued that the object of planning should not simply be to cope as best possible with the unforseeable, but to determine as far as possible what the future will be.[15] One result for the HCL of the system of planning introduced by Rochaix was that close contacts between the medical and administrative staffs were developed, and following on from this the medical staff took a greater part in administrative decision making. The 1970 Hospital Law and the Minister of Health had declared that this was one of the aims of hospital policy. However, the experience of planning carried out at the HCL led to a number of conflicts with central government. This was almost inevitable given that the director and his team were trying to formulate and implement a 'rational' and long term hospital policy for the town at the same time that the Minister of Health was attempting to cut the rate at which hospital costs were escalating.

Most hospital directors in France are now graduates of the 'Ecole Nationale de la Santé Publique' (ENSP), which partly explains the existence of a strong 'esprit de corps' and a set of values and objectives that appear to be common to this group of administrators. But it would be wrong to lump all hospital directors together. Not all are able to influence policy in this area to the same extent as M. Rochaix of the HCL. The size of a hospital is obviously a crucial factor in determining the influence of a hospital director. The individual in charge of a large regional hospital would obviously have already shown himself to possess certain qualities of leadership, organisation and authority. These

characteristics and the institution itself combine to produce a not insignificant power centre.

Not all hospitals are large institutions, and not all hospital directors are exceptional men. The conflicting interests of central and local politicians and administrators, the medical, paramedical and ancillary staff, not to mention patients and local community, are difficult to reconcile. Few hospital directors are able to surmount these pressures and exert a wider influence on the policies they are called upon to implement. The extent of the influence wielded by the hospital director therefore depends on a combination of the qualities of the individual and the size of the institution. If, as appears to be the case, the Prefect delegates the bulk of his responsibilities to the DDASS, and the mayor feels unqualified to influence decisions on hospital policy, the role of the hospital director becomes a combination of Prefect and Mayor. The hospital director is directly responsible for the day-to-day administration of the hospital, and as such is answerable to a constituency made up of medical professionals and the general public. He is also under the indirect supervision of the Ministry of Health and as such responsible for the implementation of Government health policy. The demands of the job requires a rare combination of political and administrative skills, skills normally associated with the function of the Prefect.

9.ix. **The Medical Profession**

As I have discussed in chapter three there are two contrasting approaches to this issue. In the first, the power of the profession is explained as the result of the nature of their activity. In the second, the power of the profession is seen as a function of the particular institutional features of a given country. In both, however, the power

and influence of the medical profession is assumed. From the evidence above it appears that the medical profession does play an important role in hospital policy making and implementation. In this section I will assess how important this role is, and whether this is a result of institutional features or the nature of medical activity. If the 'power' of the medical profession is a result of institutional features, are these features in any way similar to those described by analysts of French local government and politics?

Firstly it would be wrong to see the medical profession as a united cohesive force. I have already pointed out in earlier chapters the differences that exist between the private and public sectors and different specialities. A crucially important feature of the French public hospital system is the organisation of medical activity around the 'service' as opposed to the Department. The 'service' is a highly personalised system for the provision of health care within hospitals. In each hospital is a number of 'services' organised around a 'chef de service'. The 'chef de service' is answerable to no higher authority within the hospital and has no administrative responsibilities. The resources of the service depend amongst other things on the qualities and skills of the 'chef de service', not just as a doctor, but as a publicist and negotiator as well. The 'chef de service' may play an important role in obtaining resources for his hospital. As most expensive medical hardware is regulated by the 'Carte Sanitaire'. The formal procedures for obtaining the necessary central government authorisation are well defined but also long and tedious. However, as in other areas of local administration there are certain informal procedures to iron out difficulties encountered on the way. Some 'chefs de service' are more able than others at playing this game. A well known 'chef de service' or one with political contacts

is better placed to establish direct channels of communication with higher level decision making centres. The higher these contacts are the more effective these informal links are likely to be.

Given the nature of this informal network it is difficult to provide examples of this type of influence at work. However, the fact that they exist in the Rhône-Alpes and other Regions was taken for granted by the majority of the local actors I interviewed. In both the CHR's of Lyon and Grenoble I was told 'yes it does happen, but not here!' According to a member of the administrative staff of the HCL it is well known that Dr Cabanel, a 'chef de service' in the CHR of Grenoble as well as being a Deputy in the National Assembly, used his influence in Paris to swing decisions in favour of the hospital. Likewise in Grenoble it was claimed that certain decisions which benefited the HCL were a direct result of the influence of the Prime Minister at the time, R. Barre, who was also a local Deputy.

More concrete evidence is provided by the case of the allocation of a scanner to the Rhône-Alpes Region. The 'Carte Sanitaire' for the Rhône-Alpes Region allocated five scanners where four existed already. However, the 'Carte' did not stipulate where the fifth scanner should be located. According to a member of the Regional Prefect's cabinet, the fifth scanner went to Annecy in the Haute-Savoie as a result of the combined influence of the mayor and the 'chef de service' of the hospital in Annecy against a competing claim from the CHR of Grenoble.

In the case of the small town hospital it is also possible to fit the hospital into the framework of the interlocking relationship with French local government. The local doctor is a 'notable par excellence'. Like

the local solicitor, or large farmer, he is self-employed and is seen to be serving the 'interet général' of the community. His standard of living, social status and education all classify him as a 'notable', and hence as a potential mayor. The hospital doctor could find himself at one and the same time President of the Administrative Council of the local hospital as well as its employee. From mayor, he may well progress to other elected offices within local government and access to higher levels of decision making authority. In fact doctors as a profession are highly politically active. In the 1973-78 Assembly, 12% of Deputies were doctors, and during the period 1958-73 an average of 11% of Deputies in the National Assembly were doctors.[16] It would not be unreasonable to assume that a similarly high proportion of doctors can be found in the municipal and general councils of France.

One indicator of the significance of the role of hospital doctors as local politicians can be seen in the lack of success achieved by central government in their attempts to close down many of the smaller less viable local hospitals. This was one of the aims of the 1970 Hospital Law to be achieved by either the process of creating 'syndicats inter-hospitaliers' or through closure by Prefectoral decree where the 'Carte Sanitaire' showed that hospital beds were not required. In fact by 1980 the Minister of Health was forced to amend the 1970 Hospital Law as the Prefects had been unable to push through such closures against local opposition.[17] The decision to close a local hospital was transferred from the local to central level. However, the combination of local political and medical resistance appears to have been too great even for the Minister of Health to overcome, as by 1981 the Minister had been unable to force the closure of a single local hospital.

Although hospital doctors clearly participate fully in political activities and utilise the different channels of influence within French local government wherever possible, it is not clear how significant this influence is. In the first place, as I have described, the drawing up of the 'Carte Sanitaire' was a highly centralised process whereby central government laid down norms designed to freeze hospital growth. Although in common with other groups the medical profession was consulted during the process, there is no evidence to suggest that their views carried more weight than any other group. Secondly, with regard to the implementation of the 'Carte Sanitaire', where doctors were involved it was in competition with other doctors also attempting to increase the resources allocated to their particular hospital. Every case of one hospital doctor successfully influencing a decision of the Ministry of Health is therefore also the failure of another hospital doctor competing for the same scarce resource, and not evidence of the influence of the medical profession as a whole.

It therefore appears that although hospital doctors can be placed within the framework of French local government institutions it does not help to explain the extent or nature of the influence of the medical profession. The reason for this is that the issue of centre/periphery relations is essentially about the conflict between central and local politicians, despite the fact that the division is not always clear cut. The issue of 'medical power' on the other hand involves the conflict between admininstrators and doctors over the allocation of resources. This conflict takes place at the centre and at the periphery, and not between the two. As such it is perhaps more clearly understood in terms of Ashford's concept of 'Professional Monopolists and Corporate Rationalisers'.[18] The aim of the 'corporate rationalisers' - civil servants

in the Ministry of Health, the DDASS and hospital directors - was to organise the distribution of hospital resources in a more rational and planned fashion. This aim was pursued through the 'Carte Sanitaire' which formalised and bureaucratised the decision making process, and other measures contained in the 1970 Hospital Law designed to increase the authority of hospital directors over the 'chefs de service'. These objectives were pursued at both national and local levels despite the conflicts that certainly existed between the Ministry of Health, the Prefects and hospital administrators, over the degree of central control necessary.

On the other hand the 'Professional Monopolists', the 'chefs de service' and other hospital doctors in both the public and private sectors sought to maintain their traditional independence from both central government interference and control of their activities by hospital administrators and the Health Insurance Funds. As a result the particular nature of the political institutions of French local government are of less significance. However, this is not to say that the nature of medicine is the only explanation for the influence of the medical profession. As I have argued in chapter four the particularly powerful position of doctors in French hospitals can be explained in terms of the way these hospitals developed outside of central government control and how separate quasi-governmental organisations were formed to finance health care. It is only in the last fifty to sixty years that central government has begun to extend its control over this area of activity. Thus once again an important factor explaining the process of decision making in this area of policy is the fact that the institutions for the provision and financing of health care have their own particular characteristics which differ in many ways from the traditional form of French government and administration.

9.x. Conclusion

A number of important issues are highlighted by this study of the implementation of the 'Carte Sanitaire'. Although it is possible to identify groups of actors at the centre and the periphery with different and conflicting goals and values, and to fit these within the traditional framework of French local government and administration, the evidence in support of this is not overwhelmingly strong and the contribution of this approach to understanding the way in which policy is implemented is limited.

As I have suggested earlier an explanation for this may be found in the methodology. Crozier and his associates are sociologists who spent years researching at the grassroots of the French local administration. The degree of confidence between researcher and subject required to unearth evidence of the unofficial lines of communication within the French bureaucracy can only be acquired over a period of time. Given the objectives of this study this was not possible.

However, I have suggested an alternative explanation. Evidence does exist to suggest that the nature of the policy involved may explain the lack of influence of local political actors. In all of the three areas studied local political actors were quick to accept that they willingly delegated their responsibility for decisions affecting health policy to the specialists, because they did not feel qualified to intervene one way or the other in this area.

For this reason the analysis of the implementation of the 'Carte Sanitaire' in terms of local political actors and institutions is only able to contribute to our understanding of isolated events. On the other

hand a policy based approach provides a number of new perspectives and a better understanding of the process of implementation. For example it is not possible from a policy analysis perspective to give the 'Carte Sanitaire' as just another example of the non-implementation of the over-ambitious plans of government. Using a policy based approach it is possible to show the shifting objectives of the policy makers over time. Secondly this approach also places the 'Carte Sanitaire' in the context of other health policies which have sought the same objectives, and met the same pitfalls. On this basis it is possible to analyse the aims of decision makers and the policy hypothesis behind the selected plans as well as the means placed at the disposal of the implementors.

CONCLUSION

Chapter Ten

CONCLUSION

10.i. Introduction

In this analysis of health policy making in France I have sought to bring together two distinct bodies of literature. The first concentrates on the institutions of the Vth Republic in France, and the political parties and other groups that interact within these institutions. The second concentrates on the more intangible concept of 'policy'.

In the definition of policy adopted for the purposes of this thesis two important characteristics of policy have been stressed. The first is that there are a number of different ways of categorising policy, and that for different 'types' of policy the process of formulation may differ. In this context I have defined and justified a dual categorisation of policy and through the two case studies analysed the different factors involved in the policy making process.

The second characteristic of policy is that for it to be meaningful it is essential to consider both the policy making process as well as the policy implementation process.

My aim here is not to play one set of theories on French government and politics against another set of theories about policy making. This would clearly be wrong as we would be dealing with two different sets of issues. However, as I have argued, there is some evidence that the dominant approach to the French political system is showing signs of suffering from the law of diminishing returns. In the preceding

chapters I have shown that by approaching the subject from a different angle it is possible to refine and add to some of the existing theories on the French political system.

With two different approaches, as represented by the different literatures mentioned above, two different 'types' of policy, and two aspects of the policy process, there are a large number of variables to consider. In order to structure this analysis I will use the two case studies in Part III as tracers for the other variables. In other words I will examine the extent to which the different literatures provide satisfactory explanations of both policy making and policy implementation in each case and how they complement each other.

10.ii. **The Conventions Nationales**

From a purely 'institutional' viewpoint the 'Conventions Nationales' do not provide a very satisfactory subject. The negotiations between the medical profession and the health insurance organisations were not politically salient issues. They were conducted in the context of semi-governmental organisations, and indeed one aspect of government policy seems to have been to distance themselves from these negotiations. Given the apparent absence of those government actors normally associated with policy making in France, this subject would appear to provide infertile ground for an analysis using this approach.

One reason why this is so is that without a broad definition of the concept of policy, the case of the 'Conventions Nationales' would in effect not provide much useful information on the issues in question. A defeinition that encompasses both governmental decisions as well as non-decisions, what governments do as well as what they say, and the

impact in terms of policy outputs of action or inaction on the part of government, provides the basis for a more nuanced analysis. A prerequisite of any policy analysis is the existence and identification of a policy. In chapters five and six I have shown that the 'Conventions Nationales' formed a crucial part of primary health care policy in France during the seventies. Only once 'the policy' has been identified is it possible to move on to consider the process of policy making and implementation.

Policy in this area can be analysed on two levels. Firstly it is possible to identify policy changes at the macro level. In the area of primary health care policy a number of key events can be identified and seen as crucial steps in the development of French health policy. Examples of these are the creation of the first 'mutuellist' insurance societies, the creation of the 'Sécurité Sociale', the introduction of the first departmental tariff agreements, and finally the signature of the first National Convention. Similarly during the seventies shifts in policy can be identified, as the objectives of decision makers switched from extending health insurance cover to controlling the escalation of health costs.

These broad policy developments are best explained in terms of 'institutional' factors. Thus it can be argued that the creation of the 'Sécurité Sociale' was a result of the special political conditions that existed immediately after the 2nd World War. Similarly the problems faced by the new institutions once the influence of the immediate post-war liberation period wore off can be seen as stemming from the weak and ineffective governments of the IVth Republic. The arrival of de Gaulle to power and the completely new political and institutional context of

the Vth Republic help explain the sudden change of attitude to health insurance on the part of the medical profession and the introduction of the first National Convention can be understood in terms of the particular political context created by the 'New Society Program' of J. Chaban-Delmas. However, the influence of broader ideas on policy issues should not be ignored either. The shift from policies designed to improve access to health care to policies designed to control the cost of the provision of health care can be seen to have taken place in a number of western industrialised nations during the seventies.

Although all these changes can be understood in terms of the political history of France, the policy literature should not be completely ignored. Heclo has put forward the theory that while decision making tends on the whole to be incremental, this very incrementalism contributes to major policy changes that take place from time to time.[1] This supports the above analysis of the development of primary health care policy in France. For long periods change was gradual and insignificant. Intermittently major developments took place resulting in significant changes in policy. The difficult question to answer is whether these 'jumps' in policy development are the result of the gradual build up of pressure for change following years of incremental policy making which has failed to resolve policy problems, or whether these changes are by-products of institutional changes which can be explained in purely political terms.

At the micro level it is more difficult to explain the evolution of policy in terms of the political institutions of France. In chapter six I examine the role of the Minister of Health, the Prime Minister and the President in the negotiations over the three National Conventions. From the

evidence available it is not clear that the evolution of primary health care policy as seen through the three 'Conventions Nationales' was the result of conscious policy decisions taken by government and implemented under government supervision. It is clear that one of the means available to the government of the day was the ability to appoint key personnel in the health administration and the administration of the health insurance organisations. It is also clear that government thinking was strongly influenced by élite groups within the medical profession. However, this still leaves a large part of the policy process unexplained.

One part of the puzzle can be unravelled by taking a closer look at the particular institutions involved in the delivery and finance of health care. The French administration is usually seen as a homogenous whole, and analysts of the French political system have attempted to develop models of decision making applicable to the organisation as a whole, without, it must be said, much success. I would argue that the system is made up of a number of different organisations or institutions, each with its own decision making procedures. The case of the 'Conventions Nationales' illustrates this theory. For historical reasons the organisation responsible for financing health care in France is in fact not a part of the administration at all. It is a private organisation administered by representatives of the employers and employees. Despite the fact that the statutes of the organisation have been modified over the years and that its powers to raise finance and to provide services are limited by law, in contrast with the administration proper, it still has a strong sense of its own separate identity and independence and a strong democratic tradition.

Another key to understanding the process of primary health care

policy making is the system of financing health care in France. The Health Insurance Funds which covers the health costs of almost 100% of the population is not financed through general taxation but by way of contributions deducted from the wage packet and from employers. However, rather than one large insurance organisation covering the whole population, as the originators of the system had planned, there are a number of different bodies covering different sections of the population. Not all are equally efficient at collecting contributions and financing the health spending of their particular members. The health insurance organisations have a statutory obligation to balance their budgets. The outgoings of the Health Insurance Funds are made up of the honoraria of the medical profession, the cost of the drugs, laboratory tests and X-ray examinations they prescribe.

The extension of insurance cover to the whole of the population, with a system of national tariff agreements complemented by private health insurance schemes effectively reducing the cost of health care to the consumer to nil, has combined with advances in medical science to produce rapid growth in health care costs. Faced with this situation the options of the insurance organisations are limited to freezing doctors' tariffs, raising more money, or attempoting to persuade doctors to prescribe less expensive treatment. Freezing doctors' tariffs is not necessarily the answer in a system where payment is by the act. Any loss of income resulting from this can be made up by increasing the number of acts performed. In addition, policy makers seeking to enlist the cooperation of the profession in reducing other parts of the health spending equation would not risk antagonising doctors in this way. The option of raising more funds to finance expanding health costs is also unattractive given the implications this has, both politically if the

consumer is asked to shoulder these increases, and for the economy if it is the employer that has to bear the burden. The nature of the system of financing health care, as health policy analysts frequently point out, is therefore a crucial element in determining the policy making process.

The final ingredient to this conundrum is the nature of the policy problem itself. In common with other developed countries, France in the seventies was faced with rapidly rising health costs. Not all the blame for escalating health costs can be placed at the door of the medical profession. A number of factors contributed to the situation. Relatively high inflation during this period, an aging population, but most important of all the advances of medical science.

The crux of the problem faced by policy makers in France and elsewhere was therefore that unless steps were taken to control the rate at which health spending was increasing by rationing the supply of health care, a larger and larger proportion of the GNP would be devoted to financing a 'healthy' population, thus reducing the proportion of resources available for more productive policy alternatives. In France the particular characteristics of the institutions for health care financing and the fee for service system of payment of doctors meant that the process of policy making was highly complex. The gradual shift in emphasis in health policy from improving the level of cover provided by the system to rationing health care was achieved over a period of ten years through a process of continuous negotiation between the various parties involved, resulting in small adjustments to doctors' tariffs, more or less formal agreements with the medical profession on issues such as the TSAP, and the introduction of incentives of one kind or another

to discourage demand for health care. In other words policy changes were small and gradual and achieved by adjustments to various 'technical' aspects of the system for financing health care. The basis principles of the system remained unchanged however, and any shift in policy direction was implicit rather than explicit. As such the main actors involved in the policy making process were the officials of the health insurance organisations and the representatives of the medical profession. This is not to say that the political actors played no part in this process. As I argue in chapter six, certain key appointments and the privileged relations with government enjoyed by the élite of the medical profession were significant factors in the policy process. But I would also argue that at this level of policy making the subject can be more profitably approached in terms of Alford's concepts of 'corporate rationalisers' and 'professional monopolists'[2].

From this viewpoint, and on the basis of an analysis of the roles of the various groups involved in the negotiating process, a more clear understanding of how health policy developed through the 'Conventions Nationales' can be achieved. The crucial feature of this policy was that at no stage was the system of financing the delivery of health care ever in question. This explains the non-salience of the issue and the non-involvement of government. The policy making process therefore essentially consisted of the conflict between, on the one hand, the 'corporate rationalisers' and, on the other, the 'professional monopolists', in the form of the two medical unions. This conflict centred around the former's attempt to control the allocation of health resources and the latter's struggle to protect their traditional freedoms.

It has been argued by Hatzfeld and others that the introduction of

the system of tariff agreements marked the beginning of the end for the medical profession as a powerful independent group within society.[3] However, the case of the 'Conventions Nationales' and the fact that the negotiations between insurance funds and doctors remained centred on minor amendments to the tariff schedules, while the key issue, the fee for service system of payment, was successfully kept off the policy agenda, suggests that despite its divisions the medical profession remained a powerful force. The concept of 'power' used here is that defined by Bachrach and Baratz and discussed in chapter two. The medical profession exerted power not in terms of their ability to impose their will on policy makers, but in the sense that they succeeded in keeping the issue of the fee for service system of payment off the political agenda.

In the light of the above, primary health care policy in France, as seen through the 'Conventions Nationales', is to a certain extent a series of non-decisions. This raises the question of how to approach the implementation of non-decisions, and what if any is the role of those local political and administrative actors whose importance to the decision making processes is stressed in the institutional approach to the French political system? The solution is offered in chapter seven and with the case of the 'Centre de Santé de la Villeneuve de Grenoble'.

The standard approach to analysing the implementation of policy is to follow the process of decision making downwards from central government or parliament through the administration to the various decrees and statutes giving a policy effect at the local level. In the absence of an identifiable policy decision, it is impossible to compare aims or results, or analyse the means made available for the achievment

of desired ends. But it would be wrong to ignore the implications of policy making. It is therefore important to analyse the implications for policy output of non-decisions. This can be done by looking at the policy 'from the bottom up', as advocated by Barrett and Fudge.[4]

The case of the 'Centre de Santé de la Villeneuve de Grenoble' clearly illustrates the importance for the type of health care provided in France of the fee for service system of payment combined with comprehensive health insurance cover. The promoters of the Health Centre were attempting to provide an alternative to what they saw as a system of health care based on the balkanisation of the profession and an increasing reliance on technology. This view is not necessarily an accurate reflection of the nature of primary health care in France, but the experience of the Centre does illustrate the important influence of the system of financing health care, and the possible alternatives. In addition the type of health care that the Centre attempted to provide serves to highlight by way of a contrast the dominant medical philosophy.

The Mayor of Grenoble contributed to the Centre from the initial planning stages and eventually became directly involved in the administration of the Centre. As might be expected, the Mayor used his influence with the Prefect and as a 'Dèputé' in Paris in the various conflicts between the health insurance institutions and the Centre. However, it is important to note here that the main problem faced by the 'Centre de Santé de la Villeneuve de Grenoble' was the fee for service system of payment, the result of a policy non-decision, and that the various battles that the Mayor fought on behalf of the Centre were with local actors like the Prefect, and the local Health Insurance Fund. The nature of the Mayor's role in this matter was therefore significantly different from

that described by Crozier, Thoenig and others. This was not a case of a local politician resisting central policy, but rather an illustration of two very important features of this type of policy. Firstly, that although a policy may be implicit, the outcome in terms of the constraints imposed by, in this case, the fee for service system of payment, is very real. Secondly, that in the field of health policy the particular institutions that have evolved over time allow considerable local initiative.

10.ii. **Hospital Policy**

In contrast to the 'Conventions Nationales', hospital policy as seen through the 1970 Hospital Law was made quite explicit by the discussion and voting of a law in Parliament and a series of decrees aimed at implementing the aims of the Law. For this reason it is possible to analyse the various stages of the policy making process from the initiation of the policy through to the eventual results of government action.

Because of the more open nature of hospital policy making it is possible to understand at least part of the process in terms of some of the well documented characteristics of the French political system. At one level the 1970 Hospital Law provides another clear example of the important role played by the members of the 'Grands Corps' in the policy making process in France, and what might be described as their common approach and methodology which forms the cornerstone to this influence.

In chapter eight I have described the important contribution of R. Grégoire to the process whereby the 1970 Hospital Law reached the statute book. The reason I have emphasised the role played by R. Grégoire is not so much to stress the influence of a particular individual in the policy making process, but that he embodies the

characteristics and approach as well as the influence of a certain section of the bureaucratic élite in France. The methodology and language used by Grégoire in his report is typical of the 'Grands Corps'. The report that he prepared at the request of the Ministry of Health provides an excellent model of the 'national planner' approach to decision making which typifies the French bureaucratic élite. His first step was to identify the problem: his background as a member of the 'section sociale' of the 'Conseil d'Etat' and ex-president of the 'Conseil Nationale de l'Hôpitalisation' meant that he was fully conversant with the various issues in this field. His second step was to outline the various solutions: he surrounded himself with a small team consisting chiefly of fellow members of the 'Conseil d'Etat' and systematically analysed the various options. The third step was to propose the optimum solution: the optimum solution being not necessarily the most rational solution but the one most likely to result in the desired ends given the context.

This analysis of the process of policy making closely resembles what Allison has called the 'armchair rationalist' approach to policy.[5] It is of course always possible to superimpose a rationality on the actions of policy makers, but this does not necessarily provide the most satisfactory analysis of what is often a highly complex and multi-faceted process. An analysis of the 1970 Hospital Law which relies on Grégoire as the key to the process would be incomplete and misleading.

In the first place it is important to consider how hospital policy reached the policy agenda. Proposing a solution to an identified problem is only part of the policy process. Equally important is how the 'problem' reaches the policy agenda. The way in which hospital policy reached the policy agenda re-emphasises the point made earlier about the lack

of salience of health policy as an issue. Grégoire was commissioned to prepare a report on the organisation of the hospital system, not because, as the rational actor model would have it, this area had been identified as representing a problem, but following the appointment of a new Ministry of Health who on the advice of his cabinet commissioned a series of reports on various aspects of the health system in France. Thus to a certain extent rather than an identified problem in search of a policy, this is a case of a new Minister in search of a problem for which to provide a policy solution.

The lack of political salience of the issue and the fact that Grégoire was given a free hand in deciding on what issues to focus in his report means that it was the policy area itself that generated the 'policy' problem. As I have explained above, Grégoire's membership of the 'Conseil d'Etat' and his ex-presidency of the 'Conseil National de l'Hôpitalisation had familiarised him with the main issues in hospital policy. He would also have been familiar with the wider international policy context of the rapidly escalating cost of hospital care, and some of the solutions to this problem that had been adopted. It was in this context that a policy with the main objective of improving central government control over the rate of growth of the hospital system, reached the policy agenda. The policy solutions that were considered were also essentially determined by the nature of the policy problem, both nationally and internationally. Thus although on one level the process whereby the 1970 Hospital Law reached the statute book can be understood in terms of the key role played by the bureaucratic élite in the policy making process, this is only a partial explanation of the process. A more detailed analysis from a policy perspective throws up alternative explanations of the policy as well as providing insights

on the political institutions of France.

As I argue in chapter two, any analysis of policy making which seeks to be complete must address the question of how successfully policy objectives are translated into action and to what extent that action produces the desired result. In other words it is not enough to analyse the optimum solution selected by policy makers. It is equally important to look at the steps taken to implement decisions, and the end result in terms of policy output. This is a far more complex task. At one level the objectives of the 1970 Hospital Law as summarised by Grégoire in his report were not achieved. The necessary decrees and administrative reorganisation required to give the 'Carte Sanitaire' effect took over seven years to set up. When the 'Carte Sanitaire' was eventually fully operational it did not meet Grégoire's original specifications. No serious attempt was made to determine health needs. The process of measuring existing resources had become simply a matter of totalling bed numbers. One possible conclusion that can be drawn is that this is another example of the inefficiency and 'immobilisme' of the French civil service. However, it would be wrong to simply assume that the non-implementation of a policy, however rational, can be blamed on the bureaucracy. From a policy based approach there are a number of important issues to consider beforehand.

As discussed in chapter three, both Bardach and Majone have pointed out that however rational the process of policy making, if the policy assumption is basically flawed then policy objectives are unlikely to be achieved.[6] In this case the policy assumption was that it was somehow possible to objectively quantify firstly existing resources, and secondly, and more importantly, health needs. That the various parts of the

French civil service that were given the task of drawing up the 'Carte Sanitaire' failed to achieve this goal was not the result of any failings on the part of the administration, or any hostility to the objectives of the policy makers, but the flaw in the initial policy assumption.

Given the above an alternative analysis of the implementation of the 'Carte Sanitaire' is possible. The initial aim of the 'Carte Sanitaire' was to establish a system which would not only enable central government to control the growth of the hospital system, but also to promote a better distribution of hospital resources and hence more equal access to hospital care. As I have argued above, the basic policy assumption was flawed. In addition, no additional resources were made available to those responsible for the implementation of the policy. As a result the process of drawing up the 'Carte Sanitaire', the basic tool for the implementation of hospital policy, took over seven years.*

The policy makers who proposed the 1970 Hospital Law were offering solutions to problems identified by them at that time. The actors responsible for the implementation of the 1970 Hospital Law were obliged to adapt to fit the changed economic conditions and to act according to the resources at their disposal. Given the lapse of time between the drawing up of the Grégoire report and the implementation of the 'Carte Sanitaire', the nature of the policy problem and the economic environment had inevitably changed. That the health administration was able to recognise this, and was flexible enough to use a policy designed to achieve one objective, the more equal distribution of health resources, to deal with another problem, the rapid escalation of hospital

spending, suggests that the 'Mal Française' has been exaggerated and that the bureaucracy is a relatively sensitive and responsive instrument of policy.

The case of the 'Carte Sanitaire' also suggests that researchers might profitably pay more attention to the lower reaches of the French Administration and less to the 'Grands Corps' or so-called 'agents du changement'. One of the features of the French policy making process illustrated by the case of the 1970 Hospital Law is the separation that exists between the policy making functions and the implementation functions. If, as I have argued, both the policy problem and the solutions proposed impose themselves on the policy makers as a result of broader economic and societal phenomenon, and that these same issues and policies can be identified in the number of different countries at the same time, the policy making process becomes less significant, and the way in which the various solutions are implemented becomes more so.

When approaching this topic one of my initial assumptions was that the implementation of the 'Carte Sanitaire' would provide a good test case for the theories of Crozier and others on the role of the various actors in French local government. Given the legal status of hospitals within the French administrative framework, the role played by mayors in the running of hospitals, and the symbolic and economic importance of the institution, I had expected to find the 'Carte Sanitaire' to be an important local issue. In the analysis of the implementation of the 'Carte Sanitaire' I looked for evidence of the type of 'criss-cross' influence described by Crozier, and of power struggles between central and local political actors. The apparent absence of this type of informal power broking by local actors is highly significant. One possible

explanation that I have suggested is methodological. However, from a policy based perspective it can be argued that it is the nature of the policy itself which explains the apparent lack of involvement of local political actors in this area.

In the first place it is necessary to look back at the development of the French hospital system. As with primary health care, and for reasons discussed in chapter four, the French hospital system has developed its own specific institutional framework. Hospital care is provided by a variety of institutions with different status. Funding for the creation of hospitals also comes from a variety of sources. No national hospital administration exists. Public hospitals are municipal institutions, with the mayor and local politicians well represented on the administrative councils. However, from the early days the division of responsibilities between hospital administrators and medical practitioners was clearly established. The hospital administration was responsible for providing the means to enable doctors to practice their art. Medical matters were and remain the 'domain reservé' of the medical profession. This separation of powers was reinforced by the attitudes of local actors. All the local politicians I spoke to admitted that they did not involve themselves in the medical side of hospital administration as these issues were too technical, and best left to hospital doctors. At the central level the Ministry of Health has only recently become involved in attempting to control the hospital system.

This suggests that as in the area of primary health care policy the main issue is not the conflict between central and local government over the allocation of resources, but the attempt by corporate rationalisers to increase their control over the activities of the 'professional

monopolist', to use Alford's terminology. This does not rule out the centre/periphery dimension. A local mayor may well use the various avenues of influence open to him to attempt to influence central government decisions on a hospital in his municipality, and the support of the local medical community would be an additional argument to use against the services of the Ministry of Health. However, this type of conflict can be seen as part of a wider conflict between central government attempting to increase their influence over the hospital system and the medical profession struggling to maintain their traditional freedoms.

In this light, the lack of involvement of local political forces in the implementation of hospital policy appears less strange. It also suggests an explanation for the emphasis that has been placed on this aspect of the French political system by many analysts. During the sixties and seventies the system of of local government was the subject of a series of reforms, with wide ranging implications for both local politicians and the field services of the administration. The centre/periphery conflict identified by analysts may therefore be explained as a product of a policy or policies that were aimed specifically at this group of actors in the system, and not necessarily a characteristic of French local government.

10.iii. **Policy, Politics and Health Conclusion**

The 1970 Hospital Law and the 'Conventions Nationales' are two aspects of one limited area of policy making in France. However, within this limited field I have shown the complex combination of factors at play, and the different levels of explanation possible. It has never been my intention to offer an 'explanation' of the process of health policy making in France. Instead I have sought to show that there are a number

of different levels of analysis possible, and that different explanations are more appropriately applied to each.

The importance of political institutions as an explanatory variable of policy cannot be over-emphasised, but equally it should not be forgotten that the ultimate function of these institutions is to produce policies, and therefore any analysis that ignores policy is incomplete. Some aspects of both the 'Conventions Nationales' and the 1970 Hospital Law, despite the very different type of policy represented by each, can be explained in 'institutional' terms, but this provides only a one-dimensional view. The contribution of policy analysis is that it broadens the perspective and provides the opportunity to explore the different levels and different angles of the same subject. Only after further analysis of other policy areas, adopting a similar approach, would it be possible to draw general conclusions about the policy making process in France as a whole.

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ANNEX 1

Comparison between the existing Hospital Resources and those authorised by the 'Carte Sanitaire'

Sectors	Medical	Surgical	Obstetrics
1 Bourg-en-Bresse	+ 31.42	- 12.89	- 33.00
2 Oyannax, Nantua, Belley	+232.14	+112.57	+134.24
3 Annonay, Tournon	+ 33.91	+ 39.18	+ 93.54
4 Aubenas, Privas	+377.29	+ 9.69	- 13.95
5 Montelimar	+ 65.91	- 5.82	+ 10.63
6 Romans, St Vallier	+ 52.57	+ 40.25	+ 26.41
7 Valence, Crest, Die	+ 12.83	- 1.57	+ 3.77
8 Bourgoin	- 55.84	- 39.13	+ 32.65
9 Grenoble, La Mure	+ 60.65	+ 12.31	+ 33.20
10 Vienne	+ 32.22	+ 16.66	+ 24.56
11 Voiron, Rives, Pont de Beauvoisin	+ 58.89	+ 24.57	+ 38.00
12 Feurs, Montbrison	+ 2.99	+ 35.32	+ 40.00
13 Roanne, Thizy	+ 82.80	+ 4.54	+ 30.00
14 Lyon, Givors, Tarare	+ 66.43	+ 50.12	+ 50.14
15 Villefranche, Belleville, Trevoux	+ 96.68	- 27.09	+ 39.21
16 St Etienne	+ 47.46	+ 19.46	+ 44.48
17 Albertville, Bourg-St-Maurice, Moutiers	- 0.59	+ 61.36	+ 50.00
18 Chambéry, Aix-les-Bains, Saint-Jeanne de Maurienne, Saint-Pierre d'Albigny	+ 91.71	+ 25.04	+ 33.03
19 Annecy, Rumilly	+ 14.71	+ 17.42	+ 87.14
20 Anemasse, St Julien, Bonneville	+ 26.73	- 9.76	+ 21.25
21 Sallanches, Chamonix	+268.58	+ 25.64	+ 30.30
22 Thonon-les-Bains, Evian-les-Bains	+173.15	+ 44.29	+ 25.80
TOTAL	**+ 67.46**	**+ 24.17**	**+ 40.29**

(Source: Service Régional de l'Action Sanitaire et Sociale, Préfecture du Région Rhône Alpes. September 1977)

ANNEX 2

(i) **Interviews conducted in Paris**

M. J.P.Almeras	Journalist on 'Concours Médical'.
M. le Dr Aujaleu	Directeur Général de la Santé 1952-1964.
M. A.Bernard	Conseiller d'Etat, Président de la Commission Nationale d'Equipement Sanitaire.
M. Coudourier	Conseiller d'Etat.
M. de Forges	Directeur des Etudes, Ecole Nationale de l'Administration.
M. L.Fougère	Conseiller d'Etat.
M. le Dr. R.Gatelmand	Secrétaire Général, Fédération des Médecins Français.
M. R.Grégoire	Conseiller d'Etat, author of report on Hospital Policy in 'Pour une Politique de la Santé'.
M. Jannot	Conseiller d'Etat.
M. R.Joseph	Vice-Président de la Fédération des Etablissements Hospitaliers et d'Assistance Privés à But Non-Lucratif.
M. M.Jouve	Fonctionnaire de l'Assemblé Nationale, membre du Groupe de Travail Politique de la Santé du Parti Socialiste.
M. J.de Kervasdoué	Maître de Recherches au Centre de Recherche en Gestion à l'Ecole Polytechnique.
M. le Dr. Labrousse	Direction Générale des Hôpitaux.
M. J.F.Lacronique	'Chargé de Mission' au Cabinet du Ministre de la Santé.
M. D.Lecoutour	Président du Fédération Française Indépandante des Etablissements d'Hopitalisation Privées.
Mme. le Dr. M.Lies	Direction Générale de la Santé.
M. Mignon	Journalist, Directeur du 'Concours Medical'.
M. Migraine	Secrétaire Général de la Fédération Nationale des Mutuelles Françaises.
M. G.Morot	Direction Générale des Hôpitaux.
M. Olivier	Conseiller d'Etat.
M. C.Prieur	Directeur de la Caisse Nationale d'Assurance Maladie des Travailleurs Salariés.

M. C.Ramft	Spokesman on Health Policy for the CGT.
Mme. le Dr. Ripoche	Direction Générale de la Santé.
M. P.Rivière	Conseiller d'Etat.
M. V.Rodwin	Academic, Adviser to M. Cordonniou, Director of the CNAMTS.
M. C.Rollet	Inspecteur Général des Affaires Sanitaires et Sociales.
Prof. J.C.Sournia	Directeur Général de la Santé.
M. le Dr. J.C.Stephan	Medical Economist.

(ii) **Interviews conducted in Lyon**

M. F.Ampe	Maire de Chambery.
M. Bonnejean	Chargé de Mission in the Cabinet of the Director of the Hospices Civils de Lyon.
M. J.C.Cady	Directeur du Cabinet du Préfet de la Région Rhône-Alpes.
M. le Dr. J.Clier	Le Médecin Général Inspecteur Régional de la Santé.
M. Dutreil	Directeur Régional des Affaires Sanitaires et Sociales.
Mme. le Dr.M.Hayward	Direction Départementale des Affaires Sanitaires et Sociales.
M. B.Jobert	Academic, University of Grenoble.
Mme. Laurent	Adjoint au Maire de Grenoble.
Mme. Louis	Chargée de Mission au Cabinet du Préfet.
M. B.Malaterre	Administrateur, Hospices Civils de Lyon.
M. P.Mano	Directeur du Cabinet de M. Rochaix, Directeur des HCL.
M. C.Montreuil	Secrétaire Général du Conseil Régional Rhône-Alpes.
M. Noraz	Direction Départementale des Affaires Sanitaires et Sociales du Département de la Loire.
Mme. M.Perez	Spokesman on Health Policy for the PCF in Grenoble.
M. P.Ribeyre	Président du Conseil Régional Rhône-Alpes.

M. Rochaix	Directeur des HCL.
M. G.Romier	Member of the Socialist Party working group on Health Policy, Administrator of the Health Centre of Grenoble.
M. B.Venin	Adjoint au Maire de St.Etienne, Conseiller Municipal Socialiste.
M. le Dr. Weil	Doctor in the Health Centre of Grenoble.

ANNEX 3

Chronology of the Implementation of the Carte Sanitaire in the Rhône-Alpes

7 décembre 1973	'Arrêté' establishing the provisional sectorisation in the Region.
avril-décembre 1974	Creation of the 'Conseils de Groupement Interhospitaliers' in each sector by the Prefect to be consulted on sectorisation and the 'health needs' of the sector.
21 mars 1975	Creation of the 'Groupement Interhospitalier de Region'.
july-octobre 1975	GIH gives its opinion on the recommendations of the 'Carte'.
16 septembre 1974	Creation of the Commission Regionale de 'L'Equipement Sanitaire'.
4 octobre 1976	Proposed 'Carte Sanitaire' for the Region submitted to the CRES.
21 décembre 1976	Proposed 'Carte Sanitaire' submitted to the Commission Nationale de l'Equipement Sanitaire.
31 maie 1977	'Arrêté' by Minister of Health approving the 'Carte Sanitaire' of the Rhône-Alpes Region.

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